

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2016
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/23/2015 |
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| NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An unannounced annual and complaint survey was conducted at this facility from September 15, 2015 through September 23, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 68. The Stage 2 survey sample size was 34.</p> <p>Abbreviations/definitions used in this 2567 are as follows:</p> <p>Accu checks- A diagnostic test used for monitoring blood sugar levels; ADL's (Activities of Daily Living) - dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; Always/Totally Incontinent - no episodes of continent voiding during the seven (7) day review time period; AMS - altered mental status; Anxiety - an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; APM - alternating pressure mattress; AV Fistula - arteriovenous fistula/the connection of a vein and an artery, usually in the forearm, to allow access to the vascular system for hemodialysis, a procedure that performs the functions of the kidneys in people whose kidneys have failed; B&B (B/B) - bowel and bladder; Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture; B/L - bilateral/both sides;</p> | F 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *ED/NHA* (X6) DATE *10-23-15*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | Continued From page 1 BLLE - bilateral (both sides) lower extremities; Blood sugar (BS) range - the normal fasting adult blood glucose range for an adult without diabetes is 74-106; BM - Bowel Movement; BPH - Benign Prostatic Hypertrophy/enlargement of gland surrounding tube that carries urine from the bladder out of the body of men; Braden Scale - standardized tool used to determine risk for development of pressure ulcers; Bruit and Thrill - assessment of sound and sensation indicating that blood is flowing through the blood vessel and functioning properly in an AV fistula; c -with; CAA - Care Area Assessment; Caretraker - electronic system used to document services provided for a resident; cc - cubic centimeter; Cerebral Palsy - a group of problems affecting body movement and posture related to a brain injury or problems with brain development; cm - centimeter; CNA - Certified Nurse's Aide; c/o - complaints of; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Comfort/Palliative care - care that helps or soothes a person who is dying; to prevent or relieve suffering as much as possible while respecting the dying person's wishes; Continent - full control of bowel and bladder function; Contracture - a muscle that is drawn or shortened by shortening of the connective tissue around a | F 000 | | 12-2-15 |

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| F 000 | Continued From page 2 muscle OR rigid joint OR joint limitations with fixed high resistance to passive stretch of a muscle; C/S (Culture & Sensitivity) - laboratory test to identify which bacteria is causing the infection and which antibiotic will kill the bacteria; CVA - Cerebral Vascular Accident/stroke/a condition involving reduced blood supply to the brain from bleeding or from a clot; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Diabetes Mellitus - DM/disease where blood sugar levels are high due to the body's insufficient production of the hormone, insulin; Diuretic - medicines that help reduce the amount of water/excess fluid in the body; DR - dining room; DTI - Deep Tissue Injury/purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; dx - diagnosis; DON-Director of Nursing; dycem-anti-slip material; ED - Executive Director; Ensure - high calorie dietary supplement; ER -emergency room; ESRD (End Stage Renal Disease) - disease where the kidneys stop working; Femur - thigh bone; femoral neck - hip; fracture - broken bone; Frequently incontinent - seven (7) or more episodes of urinary incontinence, but at least one episode of continent voiding during the seven (7) day review time period; FSD - Food Service Director; | F 000 | | | 12-2-15 |

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| F 000 | Continued From page 3 F/U or f/u - follow up; Gerichair - recliner-a 3 position chair, upright, reclined and elevated foot rest; Hemodialysis - procedure that removes waste and extra fluid from the body when the kidneys are not functioning; H&P - History and Physical; hipster - hip padding or cover to prevent hip fracture; broken bone; Hospice - end of life care; HR- heart rate; hrs - hours; hoyer lift - mechanical patient lifting equipment with a minimum of physical effort; HS/hs - hour of sleep; HTN - hypertension - high blood pressure; hx - history; Hyperglycemia - high blood sugar; Hypoglycemia - low blood sugar; hypoxic - deficiency in amount of oxygen reaching body tissues; ICU - Intensive care unit; i.e. - that is; Incontinence (Incont. or Inc.) - loss of control of bladder &/or bowel function; IDT - Interdisciplinary Team; Interim care plan - temporary care plan in place until completion of the comprehensive assessment and comprehensive care plan are completed; Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough Insulin on its own; IV - intravenous therapy infusion of liquid substances directly into a vein; Joerns - manufacturer of specialized mattresses used for pressure ulcer treatment; | F 000 | | 12-2-15 | |

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| F 000 | Continued From page 4 Kardex - care card used for CNAs which identifies resident's care needs; L - left; Lateral - farther from the median; relating to the side; lethargic - abnormal drowsiness; LLE - left lower extremity; LOC - level of consciousness; loss of consciousness; LPN- licensed practical nurse; Malleolus - the bony protuberance on either side of the ankle; MAR - Medication Administration Record; Marathon Liquid - liquid applied to skin that forms protective barrier; MD or md - Medical Doctor; MDS - Minimum Data Set-standardized assessment form used in nursing homes; MG/DL - Milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid; MS - mental status change most often refers to an abnormal change in your responsiveness and awareness. It can affect speech, thought, mobility, memory, attention span, and/ or alertness; Mental Retardation - condition diagnosed before age 18, usually in infancy or prior to birth, that includes below-average general intellectual function, and a lack of skills necessary for daily living; ml - milliliters; Mobility - ability to move about; Modified Renal Diet - diet prescribed for individuals with ESRD who are on dialysis and reside in a healthcare setting; MOM - Milk of Magnesia/laxative; N/A - not applicable; NN- nurse's note; | F 000 | | 12-2-15 | |

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| F 000 | <p>Continued From page 5</p> <p>N/O - new order;</p> <p>Novolog Insulln - a rapid acting Insulln used to lower blood sugar/glucose in treating diabetes;</p> <p>NPUAP - National Pressure Ulcer Advisory Panel;</p> <p>n/v - nausea/vomiting;</p> <p>Occasionally incontinent - less than seven (7) episodes of incontinence during the seven (7) day review time period;</p> <p>Offload/offloading - removal of pressure from an area;</p> <p>OT- Occupational Therapist;</p> <p>Parkinson's Disease - affects the nervous system and causes muscles to become weak and arms and legs to shake;</p> <p>PASRR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or Intellectual disabilities, developmental disabilities or related conditions to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there;</p> <p>Perfusion - the act of pouring over or through, especially the passage of a fluid through the blood vessels of a specific organ;</p> <p>Peri care - perineal care/cleansing of the perineum, area between the thighs, the external genitals and anus;</p> <p>PMHx: past medical history;</p> <p>PLOF- prior level of function;</p> <p>PNA - pneumonia- lung inflammation caused by bacterial or viral infection;</p> <p>PO - oral;</p> <p>Prealbumin - a blood test to see whether you are getting proper nourishment from your diet. Specifically, the test finds out if you have been getting enough protein and if not, whether you are at risk for malnutrition or already suffering from it;</p> <p>PRN/prn - as needed;</p> | F 000 | | 12-2-15 |

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| F 000 | Continued From page 6 Prostat - protein supplement; Pt/pt - patient; PT - Physical Therapy; PU - pressure ulcer/sore area of skin that develops when the blood supply to it is cut off due to pressure; q - every; QA - quality assurance; QAA - Quality Assessment and Assurance; QAPI - quality assurance and performance improvement; RD - Registered Dietitian; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; r/o - rule out; RP - Responsible Party; SBAR (Situation Background Assessment Recommendation) - tool used to communicate between members of the health care team; SBAR Communication Form - Staff and physicians use SBAR to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy; Sepsis - potentially deadly medical condition characterized by a whole-body inflammatory state; Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film; Sliding scale with insulin coverage - a dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher; SLP - Speech Language Pathologist; S/P -(status/post)Clinical shorthand referring to a class or state that follows an intervention; | F 000 | | 12-2-15 | |

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| F 000 | Continued From page 7 S/S - signs and symptoms; SBP (systolic blood pressure) - the top number of the blood pressure that reflects pressure in vessels when the heart is beating; TAR - Treatment Administration Record; temp. - temperature; T&R - turn and reposition; Tx - treatment; U/A (Urinalysis) - diagnostic test used to detect and assess a disease or illness OR diagnostic test used to determine presence of infection; UM - Unit Manager; Urinary incontinence- inability to prevent accidental leakage of urine from bladder; Urosepsis - severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream; UTI - Urinary Tract Infection; Voiding Diary - 3-Day Bowel & Bladder Flow Sheet/ a record of moving one's bowels and voiding (urinating) for 72 hours or 3 days to determine patterns; w/c - wheelchair; WCC - Wound Care Certified; X-ray - picture taken of bones or organs; + - positive; > - greater than; < - less than. | F 000 | F225 1. Resident (R11) resides at the facility. Resident (R11) incident was report to the state Agency 2 days later than required. 2. All residents who reside in the facility are at risk for being impacted with this deficiency. An audit of the past 90 days will be performed to identify any reported incidents that were not reported in the required timeframe. 3. The facility failed to report incident follow up to the state agency within 5 working days. All state reportable incidents will have follow up investigation reported to the state agency within 5 days. The Administrator will be in serviced on the proper procedure of reporting incidents to the state by Regional Director of Health Service on 10/15/15. 4. Administrator will perform weekly audits of reportable incidences by the DON/ADON daily x4 weeks until 100% then monthly x 2 months until 100%. Results will be brought to QAPI to determine further monitoring. | | 12-2-15 |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/ REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a | F 225 | | | |

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| F 225 | <p>Continued From page 8</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review and review of other facility documentation, it was determined that for one (R11) out of 34 Stage 2 sampled residents, the facility failed to ensure that the results of the investigation of R11's "injury of unknown origin" were reported to the State Agency within 5 working days. Findings include:</p> | F 225 | | 12-2-15 | |

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| F 225 | Continued From page 9 Review of the facility policy, dated 10/10/08 and entitled, "Abuse Prohibition and Prevention Program" stated, "...Investigation. Any allegations involving...Injuries of unknown source ...will immediately be reported to the Executive Director and appropriate state enforcement/ regulatory agencies...Director or designee will submit a report of the investigation to the appropriate state agency within 5 working days of the incident, unless otherwise indicated by state law or regulation...". Review of R11's incident report and investigation, dated 8/18/15, for an "injury of unknown origin" stated that during morning care, R11 complained of right knee pain, was unable to bear weight and was unable to state what happened. R11's right knee was observed to be swollen and he was sent to the hospital. Subsequently, R11 was readmitted to the facility on 8/21/15 with a diagnosis of a right femur fracture. R11's incident report of an "injury of unknown origin" was initially reported to the State Agency on 8/18/15. Review of the five (5) day follow up report (due by 8/25/15), revealed that the investigation was completed on 8/22/15, however, the 5 day follow up was not submitted to the State Agency until 8/27/15 (7 working days later). During an interview on 9/22/15 at 10:46 AM, E2 (DON) confirmed this finding. The facility failed to submit a timely 5 day follow up report to the State Agency as required by law. | F 225 | F246 1. Resident (R10) still resides at the facility. Resident's call bell was placed to where resident could reach it 9/15/15. 2. All residents who reside in the facility have the potential to be impacted by this deficiency. An inspection of all residents' rooms will be performed to ensure that the residents are able to reach the call bells 3. Facility failed to place the resident's call light to where she could reach it. The Director of nursing/designee will in-service nursing staff on appropriate placement of call bells within residents reach. 4. Placements of call bells will be audited by DON/Designee 3 times per week until 100% compliance is reached for 3 consecutive evaluations, then weekly until 100% compliance for 3 consecutive evaluations then a month later. Results will be brought to QAPI to determine further monitoring. | | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive | F 246 | | | |

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| F 246 | Continued From page 10 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility failed to have call lights within reach for one (R18) out of 34 residents. Findings include: An observation was made on 9/15/15 at 12:19 PM of R18 sitting in a wheelchair with the resident's bed to the left side. R18's left hand had a contracture and the call button was clipped to the bed. When asked R18 was unable to reach the call button. Findings were reviewed with E3 (ADON) on 9/21/15 at 1:36 PM. Findings were reviewed with E1 (ED), E2 (DON) and E3 on 9/23/15 during the exit conference at approximately 4:20 PM. | F 246 | F248 1. Resident (R10) remains at the facility. Resident's CD player is fixed and functioning. Activity staff to play Saxophone music CD's for the resident to enjoy and care plans have been updated. 2. All residents have the potential to be affected by this practice. All Activity care plans have been reviewed and revised. All activity care plans will be reviewed for accuracy and appropriateness and revised as needed by Activities Director/designee. 3. Facility failed to appropriately capture activities through documentation and failed to update the activity care plan to reflect any changes on resident. All activity staff will be in-serviced by the Administer/designee on care plan updating, documentation of activity participation and offering activities which are appropriate with the residents' plan of care. Activities Director will be responsible for all activities care plans reviews and updates. Activities assistant will receive training by administrator/designee to do care plan updates and reviews in the absence of the activity Director. | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/ NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by | F 248 | | 12-2-15 |

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| F 248 | Continued From page 11 Cross refer to F323 example 1 Based on record review, observations and interview, it was determined that the facility failed to provide activities of interests designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for one (R10) out of 34 stage 2 sampled residents. Findings include: R10 had diagnoses that included advanced dementia, anxiety, depression and a history of falls. R10's care plan for Activities, initiated on 8/16/13 and last reviewed on 11/5/14 listed a Long Term Goal Target date of 11/17/2015 with goals of "I will participate in 0-1 activities per week thru next review" and "I will accept daily 1:1 visits by staff thru next review." The Care Plan approaches included: Current activity programs: Mass/Communion; Music (used to play the Saxophone); current events (somewhat), Bingo; Daily visits by staff (this includes during resident care, therapy, activity programs, meals etc.); encourage participation; If I do not wish to talk with you, please sit and keep me company; Invite daily to unit activities; Sit me close to the TV/speaker/singer; Transport me to activities as needed; Visits by family and friends. 2/5/15-E9's (Recreational Assistant) Quarterly Note stated that R10 "stays in her room. She gets occasional visitors. She walks with staff daily in the hallways. Continue to follow CP (Care Plan) goals and approaches". | F 248 | 4. The MDs coordinator will audit a sampling of 5 resident's activity documentation and care plan completion and accuracy daily until 100% compliance is reached for 3 consecutive evaluations, then weekly X 4 weeks until 100% compliance then monthly x 2 months until 100% compliance. Results will be brought to QAPI to determine further monitoring. | 12-2-15 |

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| F 248 | <p>Continued From page 12</p> <p>5/7/15-Annual MDS assessment indicated that R 10 was severely cognitively impaired, she did not ambulate and was dependent of staff for all ADLS that included moving between locations in her room and to and from off-unit locations, such as activities and dining.</p> <p>5/7/15 - Annual MDS assessment indicated that R10 was interviewed for Activity Preferences with R10 as the primary respondent. R10 indicated that it was very important to her to listen to music that she likes and to participate in religious services. Also somewhat important was to do things with groups of people, to go outside to get fresh air when the weather is good and important to do her favorite activities.</p> <p>There was no activity follow up quarterly note found in R10's clinical record since 2/5/15.</p> <p>During a tour on 9/16/15 at approximately 10:15 AM, R10 was observed in her room, in her geri-chair facing the doorway, in a reclined position with her legs elevated and eyes closed. R10 was alone and her room was located approximately 8 rooms away from the nursing station. R10 was located next to the window and further away from the doorway. The TV was not on.</p> <p>9/17/15 at 10:55 AM-R10 was observed in her room, alone, in her reclined geri-chair with her legs elevated, and she was making mumbling sounds with her eyes closed. The TV was not on.</p> <p>9/18/15 at approximately 10:45 AM and between 1:30 - 2 PM-R10 was observed in her room, laying in her bed crying, with her eyes closed and alone. The TV was not on.</p> | F 248 | | 12-2-15 | |

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| F 248 | <p>Continued From page 13</p> <p>9/23/15 at 11:35 AM, during an Interview with E9 (Activity Assistant), she stated the following: Communion was given 3 Thursdays per month and mass 2 times per month on the 2nd Tuesday and the 4th Thursday of each month. R10's name was given to the person who administered the communion, but she was not sure if R10 received communion or not as they (activity staff) did not follow up and document the results of this planned activity. E9 also stated that the 1:1 visits were not scheduled daily for each resident, they are carried out whenever staff have a chance to do them.</p> <p>In addition, the facility was aware that R10 used to play the saxophone. When E9 was asked if the facility provided CD's of saxophone music for R10 to listen to, E9 stated no.</p> <p>R10's activities daily Program of Attendance Record (April 2015-September 22, 2015): Indicated the following: 0 (blank) record of attendance for music/entertainment; 1 out of 12 for Chapel Service/Spiritual attendance; 3 attendances for Trivia/Daily Chronicle/Current Events; 2 coffee chat; 1 movie; 2 chalrobics and 2 group games. There were 48 1:1 recorded staff visits, and 3 family visits out of 175 days from April 2015 - September 22, 2015 on R10's daily Program of Attendance Record.</p> <p>The facility failed to ensure that R10 was provided activities designed to meet her interests and in accordance with the comprehensive assessment and plan of care.</p> <p>This finding was discussed with E10 (Director of Activities) and E9 on 9/23/15 at approximately 11:35 AM and with E1 (ED) and E2 (DON) on 9/23/</p> | F 248 | | | |

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| F 248 F 253 SS=E | Continued From page 14 15 at approximately 3:00 PM. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by ! Based on observations and interview, it was determined that the facility failed to have housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for the main dining room and 20 (500, 501, 502, 510, 513, 600, 604, 605, 606, 607, 609, 611, 612, 613, 702, 706, 708, 710, 716, and 717) out of 31 rooms reviewed. Findings include: Observations during the environmental tour with E17 (Housekeeping Supervisor) on 9/21/15 from 2:00 PM - 2:40 PM revealed the following: -Main Dining room: dirty wall, missing and broken ceiling tiles; -Room 500: loose bathroom door knob, bathroom wall in disrepair, scraped bathroom door on the inside, peeled linoleum flooring; -Room 501: scraped bathroom door on the inside, loose bathroom door knob; -Room 502: dirty bathroom floor; -Room 510: stained carpet; -Room 513: scraped bathroom door (inside and outside), peeled paint on doorframe; -Room 600: scraped bathroom door (inside and outside); | F 248 F 253 | F. 253 1. All repairs were completed after the survey: Room 500 doorknob repaired, bathroom wall repaired, door repaired, flooring repaired; Room 501 bathroom door repaired, bathroom doorknob repaired; Room 502 bathroom floor cleaned; Room 510 carpet cleaned; room 513 bathroom door repaired, doorframe painted, room 600 bathroom door repaired; room 604 bathroom door repaired; room 605 bathroom door repaired, door frame painted, bedroom door repaired; room 606 paint repaired, bathroom door repaired, electrical outlet plate replaced, room 607 door and door frame painted, room 609 closet and bathroom doors painted, room 611 bathroom door painted, ceiling tiles replaced; room room 612 toilet paper holder repaired, bathroom wall repaired, doorframe painted; 613 doors and door frames of closets painted, bathroom door and frame painted; room 702 bathroom door and door frame painted, wall in bathroom repaired, new flooring was installed; 706 lampshade replaced, closet door cleaned, bathroom door and frame painted, wall painted; 708 overbed table replaced, gerichair was replaced; | 12-21-15 |

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| F 253 | Continued From page 15 -Room 604: scraped bathroom door (inside and outside); -Room 605: scraped bathroom door (inside and outside, chipped paint on doorframe, scraped wall behind the bedroom door); -Room 606: peeling and cracked paint above bathroom sink, scrapes on inside and outside of bathroom door, cracked electrical outlet plate; -Room 607: scraped bathroom door and doorframe (inside and outside); -Room 609: scraped closet and inside and outside of bathroom doors; -Room 611: chipped paint on inside of bathroom door, stained ceiling tiles, broken ceiling tile; -Room 612: loose toilet paper holder, unrepaired wall under newly installed soap dispenser, inside bathroom door and doorframe scraped and peeled; -Room 613: doors and doorframes of closets scraped, scrapes on inside of bathroom door and doorframe; -Room 702: scraped inside bathroom door and doorframe, unrepaired wall near newly installed toilet paper holder, very worn carpet; -Room 706: bedside lampshade damaged, dirty closet door, scraped outside bathroom door, doorframe and wall; -Room 708: cracked corner on over bed table, torn leather on both arms of Gerichair; -Room 710: scraped upper bathroom wall, cracked corners and edges on over bed table; -Room 716: cracked corners and edges on over bed table; and -Room 717: scraped closet door, gaping ceiling tile. Findings were confirmed by E17 on the environmental tour on 9/21/15 from 2:00 PM - 2:40 PM. | F 253 | F 253 room 710- bathroom wall painted, over bed table replaced, room 716 overbed table replaced; room 717 closet door painted, ceiling tile replaced.----- 2. All resident areas are at risk for this deficient practice. All other rooms were evaluated for cleanliness and need of repairs. The findings are as follows and all repairs were made- room 600, 602, 604, 609, 610, 613 all touch up painted to walls, door and closet door; room 603 closet door painted; room 500 closet door painted; 506 closet door trim painted; 500 hallway fixed light fixtures and cleaned all overhead fixtures; 700 door painted, 701 closet and bathroom doors painted; 702 bathroom painted; 707 bathroom painted; 706 bathroom painted and closet door; 708 bathroom painted; 716 wall repaired in bathroom, door painted. Facility failed to have housekeeping and maintenance services necessary to maintain a sanitary, orderly, comfortable interior. All resident areas are at risk for this deficient practice. 3. A knowledge deficit was identified of the maintenance workers on the proper way of checking a resident room for | <i>12-2-15</i> |

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| F 253 | Continued From page 16 | F 253 | <p><i>F253</i></p> <p>maintenance issues. Maintenance workers will be educated by the maintenance director on the proper way to conduct checks of a resident room. There was a knowledge deficit of the housekeeping staff on proper detail cleaning of a resident room. Housekeepers will be educated by the housekeeping manager on proper procedure for detail cleaning a room.</p> <p>4. The maintenance director will conduct a sampling of 5 resident rooms for documentation of work orders and completion of repairs daily for 3 days until 100% compliance is achieved, then once per week x 3 weeks until 100% compliance reached, then one month later to ensure compliance. Results will be brought to the QAPI team to determine further monitoring.</p> | 12-2-15 | |
| F 272 SS=D | <p>Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 9/23/15 during the exit conference at approximately 4:20 PM.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> | F 272 | | | |

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| F 272 | Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, it was determined that the facility failed to comprehensively and/or accurately assess two (R 7 and R12) out of 34 Stage 2 sampled residents. The facility failed to comprehensively assess R7's and R12's urinary incontinence upon admission and/or readmission to the facility. Findings include: 1. Cross refer F315 example #2 R7 was admitted to the facility on 6/3/15 with diagnoses that included dementia, BPH and history of a CVA. The facility's admission Data Collection Tool, dated 6/3/15, stated that R7 was alert and oriented to person and place, that his short and long term memory was intact, and he was incontinent of bladder and used pads or briefs. A Bladder Incontinence Assessment, dated 6/3/15, was incomplete. It failed to identify contributing factors/diagnoses that could influence R7's continence status, such as dementia and urinary disorders from the prostate. The section "Bladder Status" on page 1 was blank, except for a notation that the buttocks had some redness. Pages 2 and 3 were blank. The Summary portion of the assessment (page 3) stated after review of the Bladder Incontinence | F 272 | F 272 1.a. Residents (R7) still reside at the facility. 3 day voiding diary have been completed, reviewed, incontinence assessment completed, care plans and proper interventions in place. 1.b. Residents (R12) still reside at the facility. 3 day voiding diary have been completed, reviewed, incontinence assessment completed, care plans and proper interventions in place. 2.a. All residents who are Incontinent of bladder have the potential to be impacted by this deficiency. The DON/ Designee will review all Identified residents voiding diary and Incontinence assessments for completeness and accuracy. Care plans will be reviewed and appropriate interventions discussed at IDT meeting. 2.b. All residents who are Incontinent of bladder have the potential to be impacted by this deficiency. The DON/ Designee will review all Identified residents voiding diary and Incontinence assessments for completeness and accuracy. Care plans will be reviewed and appropriate interventions discussed at IDT meeting. | 12-2-15 | |

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| F 272 | <p>Continued From page 18</p> <p>Assessment and the 3 Day Bowel and Bladder Flow Sheet; a determination was to be made whether the resident was a candidate for a retraining program. Page 4, the "Bladder Retraining Progress Notes," dated 6/3/15 stated, "Alert and Oriented x 2 (to person and place); Resident stated sometimes he has accidents Resident incontinent of bladder (occasionally) wears pull-ups and adult diapers (per resident) No c/o pain during urination. Soft nondistended abdomen. "</p> <p>R7's clinical record revealed that although a 3-Day Bowel & Bladder Flow Sheet (voiding diary) was dated to start at 12 midnight on 6/3/15 (should have been dated 6/4/15), it was never completed. The facility failed to ensure a voiding diary was completed and they failed to develop an individualized toileting plan based on the voiding diary for R7.</p> <p>The 6/10/15 admission MDS assessment stated R7's daily decision making skills were severely impaired and that he required extensive assist of one staff for transfers and toilet use. The MDS also stated R7 was frequently incontinent during the assessment period (6/4/15 through 6/10/15) and there was no trial of a toileting program.</p> <p>Findings were reviewed with E2 (DON) on 9/22/15 at 11:30 AM.</p> <p>The facility failed to comprehensively assess R7's urinary continence status on admission and they failed to complete a voiding diary.</p> <p>2. Cross refer F315 example #1 R12 was admitted to the facility on 5/14/15 with diagnoses that included diabetes mellitus,</p> | F 272 | <p>F272</p> <p>3. a. The facility failed to ensure that 3 day voiding diary and incontinence assessments were completed and accurate. All new and readmitted residents will have a 3 day voiding diary completed, results will be reviewed at the IDT meeting then incontinence assessment will be completed if resident is deemed as incontinent, care plans will be developed with appropriate interventions. The MDS /RNAC will communicate any changes in urinary incontinence when MDS assessments are completed. Voiding diaries, incontinent assessments, care plans will be reviewed at the IDT meeting. The DON/Designee will in-service nursing staff on the 3 day voiding diary and incontinence assessment procedure. The RNAC/MDS coordinator will be in serviced by DON/designee to report any changes in incontinence assessments to the DON/Designee.</p> <p>3.b. The facility failed to ensure that 3 day voiding diary and incontinence assessments were completed and accurate. All new and readmitted residents will have a 3 day voiding diary completed, results will be reviewed at the IDT meeting then incontinence assessment will be completed if resident is deemed as incontinent,</p> | <i>12-2-15</i> | |

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| F 272 | <p>Continued From page 19 hypertension, dementia and UTI.</p> <p>R12's admission Data Collection Tool, dated 5/14 /15, stated the resident was lethargic, had poor decision making, and R12's bladder function was left blank. In the bladder function of this form, it prompted the person filling it out to complete the required Bowel and Bladder forms if the resident was incontinent.</p> <p>A four page Bladder Incontinence Assessment, undated, was blank, except for R12's first and last name, the attending physician, and the room number. R12's assessment had no information regarding the resident's current status, bladder status, potential causes of incontinence, exams, summary and whether R12 was a candidate for a retraining program.</p> <p>There was lack of evidence in the clinical record that upon admission a bladder assessment or a 3 -Day Bowel and Bladder Flow Sheet (3-Day Voiding Diary) was done. The facility failed to ensure a voiding diary was completed and analyzed in order to develop an individualized toileting plan.</p> <p>The admission MDS assessment, dated 5/21/15, stated R12 was moderately impaired (decisions poor; cues/supervision required). The same MDS stated she required extensive assist of one person for transfers and toilet use and was frequently incontinent. Also this MDS stated R12 had a diagnosis of UTI within the last 30 days, received a diuretic during the seven (7) day review time period (5/15/15 through 5/21/15) and was not on a trail toileting program.</p> <p>Findings were reviewed with E2 on 9/22/15 at 11:</p> | F 272 | <p>F272</p> <p>care plans will be developed with appropriate interventions. The MDS /RNAC will communicate any changes in urinary incontinence when MDS assessments are completed. Voiding diaries, incontinent assessments, care plans will be reviewed at the IDT meeting. The DON/Designee will in service nursing staff on the 3 day voiding diary and incontinence assessment procedure. The RNAC/MDS coordinator will be in serviced by the DON/designee to report any changes in incontinence assessments to the DON/Designee.</p> <p>4.a. The DON/ Designee will audit all new and re admissions for 3 day voiding diary an incontinence assessments for accuracy and completeness weekly x4 until 100% compliance then random audits x2 months. The results will be brought to QAPI to determine further monitoring.</p> <p>4.b. The DON/ Designee will audit all new and re admissions for 3 day voiding diary an incontinence assessments for accuracy and completeness weekly x4 until 100% compliance then random audits x2 months. The results will be brought to QAPI to determine further monitoring.</p> | 12-2-15 | |

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| F 272 | Continued From page 20 12 AM. | F 272 | <p>F278</p> <ol style="list-style-type: none"> Resident (R11) still resides at the facility. The RNAC has filed for a modification to the MDS assessment that was incorrectly coded on 11/4/14 under PASRR. RNAC reviewed MDS for completion of R11's MDS and re-sign the attestation 10/21/15 All residents residing at the facility with a MR Diagnosis have the potential to be impacted by this practice. The DON/ Designee will review all residents' medical records to identify any resident with the diagnosis of MR. Any resident identified with a diagnosis of MR will have MDS assessments reviewed by the RNAC to ensure proper coding. The facility failed to ensure proper MDS coding and accurate signing of the completion of MDS assessments. There was knowledge deficit of the social service director who is not employed by the facility at this time on proper coding of the MDS assessment section, knowledge deficit of the MDS coordinator to ensure that MDS assessments are signed accurately on the completion dates. RNAC/ MDS Coordinator, and new Social service director will be in serviced by the DON/Designee on | 12-2-15 | |
| F 278 SS=D | <p>483.20(g) - (j) ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> | F 278 | | | 12-2-15 |

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| F 278 | <p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R11) out of 34 Stage 2 sampled residents, the facility failed to ensure the accuracy of three MDS assessments. Findings include:</p> <p>A. R11's clinical record included a PASRR Assessment, dated 7/27/09 which stated, "...need for nursing facility services...assist c (with) all ADL's and medical mgmt (management)...; Identification of possible Mental Retardation of related conditions...Indicate condition...mental retardation & cerebral palsy...".</p> <p>Review of R11's annual MDS assessment, dated 11/4/14, was incorrectly coded as "0" (No) under Preadmission Screening and Resident Review and the facility failed to check any of the PASRR conditions listed.</p> <p>During an interview on 9/21/15 at 10:40 AM, E4 (RNAC) confirmed the findings.</p> <p>B. R11 had a quarterly MDS assessment completed in July 2015. E4 verified and certified with her signature that this assessment was completed on 7/16/15. E40 (RD) and E45 (Director of Rehabilitation) each signed that their sections were complete on 7/18/15.</p> <p>C. R11 had a significant change MDS assessment completed in September 2015. E4 verified and certified with her signature that this assessment was completed on 9/7/15. E45 however, signed that two sections were complete as of 9/8/15.</p> | F 278 | <p>F278</p> <p>proper coding and signing of the MDS assessments when completed.</p> <p>4. The MDS coordinator/ RNAC will audit 5 residents MDS assessments to ensure accurate coding and assessment completion dates are accurate daily x 3 weeks until 100% compliance then random audits one month later to ensure compliance. The results will be brought to QAPI to determine further monitoring.</p> | 12-2-15 | |

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| F 278 | Continued From page 22 | F 278 | | |
| F 280 SS=D | <p>During an interview on 9/21/15 at 10:40 AM, E4 confirmed that she documented that all sections were complete prior to other staff signing off their sections and confirmed that therefore her attestation was not accurate.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R10, R11, R12 and R19) out of 34 sampled residents the facility failed to revise the care plan to reflect actual care needs. Findings Include:</p> | F 280 | <p>F280</p> <ol style="list-style-type: none"> Resident 19 no longer resides at the facility. Resident R10 resides at the facility. Resident R11 resides at the facility. Resident R 12 resides at the facility. Resident R19, R10, R11 and R12 care plans have been reviewed and revised. All residents residing in the facility have the potential to be impacted by this deficiency. All residents who have diagnosis of MR, Incontinent of urine and are at risk for falls will have their care plans reviewed and updated to reflect their current status. The facility failed to update, review and revise care plans. There was knowledge deficit of staff regarding accurate care plan reviews and updates. Licensed nurses, activities staff, Social service director, MDS/ RNAC will be in serviced by the DON/Designee on care plan reviews/updates. The DON/ Designee will review 5 resident's care plans daily x 3 weeks for accurate care plan reviews and update until 100% compliance is reached then weekly random audits x 3 weeks until 100% compliance is reached. The audits will be presented to QAPI to determine further monitoring. | 12-2-15 |

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| F 280 | <p>Continued From page 23</p> <p>1. R19 had a care plan developed on 8/6/15 for ESRD requiring hemodialysis. A care plan intervention stated to check the resident's AV fistula for bruit and thrill. Although R19 had an AV fistula in the left upper arm, according to an interview with a family member on 9/22/15 at 4:00 PM, the AV fistula was non-functioning (therefore there would be no bruit or thrill) and it had not been in use for approximately 4 to 5 months.</p> <p>The facility failed to revise the care plan to reflect that R19's bruit and thrill were not being checked on the AV fistula.</p> <p>Findings were reviewed with E2 (DON) on 9/23/15 at approximately 2:00 PM.</p> <p>2. The facility policy, dated 9/25/14 and entitled, "Process for Care Plan Development and Communication" stated, "...Once the interdisciplinary team determines a significant change has occurred, the resident plan of care should be updated...".</p> <p>During an observation on 9/17/15 at 9 AM a driver from DART transportation requested to take R11 to his Adult Day Care Program. E2 informed the driver that R11 had "not been going lately" and was "on hold indefinitely" at this time.</p> <p>R11's care plans included a care plan, dated 8/11/14 and entitled, "...Activities... Activity needs related to having limited mobility and he goes out to an Adult day care program Monday thru Friday" which included documentation dated 1/23/15 to "...Continue as Above".</p> | F 280 | | | 12-2-15 |

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| F 280 | <p>Continued From page 24</p> <p>R11's activity notes, dated 8/26/15 stated, "...will continue to go back to the Adult day program once he is feeling well again..."</p> <p>R11's social service notes, dated 9/1/15 stated, "...Due to his current fracture he hasn't been to the day program..."</p> <p>During an interview on 9/21/15 at 9:06 AM, findings were discussed with E2. E2 stated that R 11 was readmitted to the facility on 8/21/15 with a femur fracture and that R11's attendance at the Adult Day Care Program was "on hold" until the follow up with his doctor to determine if/when he would resume attending the Adult Day Care Program. E2 disputed the documentation that R 11's care plan was last reviewed on 1/23/15 and showed this surveyor a cover sheet to R11's care plans, entitled, "Evaluation of Care Plan". It stated the last "Review Date" was 9/7/15 and it was initialed by E4 (RNAC). Although E2 confirmed that R11's activity care plan had not been revised, he stated that this page indicated that "all" of R11 's care plans were last reviewed and updated on 9/7/15.</p> <p>During an interview on 9/21/15 at 10:40 AM, E4 was questioned regarding her initials and the documentation on 9/7/15 that R11's care plans were "Reviewed and updated" by her. E4 denied reviewing or updating R11's activity care plan. E4 stated that she was instructed "by the ADON to sign that care plans were reviewed and updated". E4 stated she does not review and revise the " activity, nutrition, therapy or social service care plans". E4 stated that other departments were responsible for reviewing/revising these care plans. E4 stated that she completed R11's</p> | F 280 | | 12-2-15 |

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| F 280 | <p>Continued From page 25</p> <p>Signficant Change MDS, dated 9/1/15 and then Informed this surveyor which of R11's care plans she reviewed. E4 confirmed that none of the care plans she reviewed were documented individually that they were reviewed by her. E4 also confirmed that her documentation on the " Evaluation of Care Plan" sheet was not accurate, as it did not list which care plans she actually reviewed. E4 confirmed that the facillity failed to review and revlse R11's activity care plan and agreed that her documentation was not accurate.</p> <p>Findings were discussed with E2 during an interview on 9/21/15 at 12:38 PM. E2 stated when he read that the care plans were updated...he belleved from that documentation that all of the care plans were reviewed and revised. E2 denied being aware that E4 only reviews certain care plans and not all. The facillity failed to review and revlse R11's activity care plan regarding his attendance at the Adult Day Care Program which had been on hold since his return to the facillity on 8/21/15. Additionally, the facillity failed to recognize it had a system fallure with regard to ensuring that all resident's care plans were reviewed and revised.</p> <p>3. On 5/25/15 a urinary incontinence care plan was developed for R12. It was reviewed and updated on 8/14/15. Approaches included: Incontinence care as needed after each episode of incontinence, monitor for increased episodes of incontinence, and one person assistance with toileting. In the same care plan an approach was yellowed out (discontinued) that stated, "Toilet/ check/change resident upon rising in AM, before & after meals, at bedtime and every 2 hours</p> | F 280 | | 12-2-15 | |

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| F 280 | <p>Continued From page 26 during the night". Handwritten and undated was an approach that stated, "Check and change q round and PRN." It was unclear when the approach to "check and change q round (usually every 2 hours) and PRN" was implemented, as it was undated.</p> <p>Although the facility reviewed and updated R12's urinary incontinence care plan on 8/14/15, they failed to update the care plan to reflect that R12 was hospitalized in the month of July for a UTI.</p> <p>Findings were reviewed with E2 on 9/22/15 at 11:12 AM.</p> <p>Cross refer to F323, example 1 4. R10 had a care plan entitled "Potential for Injury related being (sic) a fall risk due to decreased mobility, decreased cognition/lack of safety awareness, episodes of anxiety/behaviors, hx of falls, medication and adl decline" with review dates of 12/1/14, 2/12/15, 4/30/15, 5/9/15 and 11/21/15. The stated goal was that she would have no injury related to a fall thru the next review . The care plan approaches included: administer medication per order, ensure foot wear has non-skid soles, keep bed in lowest position safest for me, keep call bell in reach encourage to use prn, Therapy evaluation/screen/treat, toilet/ incontinence care every round and prn, Transfer with 1 assist, mechanical lift x 2 assist, bed and chair alarms, hipsters, and fall mat.</p> <p>Record review revealed that R10 had unwitnessed falls on 12/1/14, 4/29/15 and 5/13/15</p> <p>While the facility identified that R10's 3 falls were unwitnessed while in a gerl-chair, the facility failed</p> | F 280 | | 12-2-15 |
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| F 280 | Continued From page 27 to revise the care plan to identify the problem of R 10's actual falls and failed to evaluate the interventions and failed to include new interventions to include R10's need for adequate supervision to prevent fall with injury. In an unwitnessed/unsupervised fall on 8/5/15 R10 sustained a hip fracture. Findings were discussed with E2 and E16 (Regional RN) on 9/22/15 at approximately 3:00 PM. | F 280 | F309 1. a. Resident R 26 resides at the facility. Resident R 26 remains stable, bowel assessment was completed 9/24/15. | 12-2-15 |
| F 309 SS=D | 483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the plan of care for two (R19 and R26) out of 34 Stage 2 sampled residents. The facility failed to provide the correct foods, according to dietary restrictions for R19, who was on a Modified Renal Diet, and failed to implement the bowel protocol for R26 according to physician's orders. Findings Include: 1. According to the "Simplified Diet Manual, | F 309 | 1.b. Resident 19 no longer at the facility, discharged 10/1/15. Dietary staff was notified of the resident's renal dietary restriction and orange juice was no longer provided. 2.a. All residents are at risk for this practice. An audit of all residents past 2 weeks of BM records will be completed to identify any resident who did not have a BM in 3 days. Those residents who were identified will have a bowel assessment completed. 2.b. Residents on a renal diet are at risk for this practice. The dietitian will review all dietary restrictions to identify any resident on a renal diet. The dietary staff was notified of those identified so that orange juice will not be offered. 3.a. The facility failed to follow the BM protocol. Licensed nursing staff will be in serviced by the DON/Designee on the facility's BM protocol and how to obtain the information. The DON/Designee will run daily report on the residents triggering for no BM'S in 3 days and follow up with the licensed nurses to ensure that | 12-2-15 |

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| F 309 | <p>Continued From page 28</p> <p>Eleventh Edition," published 2012, and utilized by the facility, the Modified Renal Diet was usually limited in potassium to avoid dangerous levels that could cause heart problems. The manual stated, "The following steps will decrease potassium for the Modified Renal Diet: Substitute citrus, prune, tomato, and vegetable juices with cranberry, apple, or other lower potassium juice ..."</p> <p>R19's admission orders, dated 7/28/15, included an order for a Modified Renal soft Diet.</p> <p>A care plan for alteration in nutritional status, dated 8/3/15, included the approach, "diet as ordered mechanical soft/modified renal."</p> <p>Observations of R19 on 9/17/15 at 8:25 AM and 9/22/15 at 8:52 AM revealed R19 eating breakfast. On both of these days, R19 was observed to have been served and drank 6 ounces of orange juice (citrus).</p> <p>The facility failed to follow physician's orders for a Modified Renal Diet when R19 was served orange juice on 9/17/15 and 9/22/15 during breakfast.</p> <p>Findings were reviewed with E2 (DON) on 9/23/15 at approximately 2:00 PM.</p> <p>2. Review of the undated facility "Bowel Protocol" stated, "If no bowel movement in 3 days give 30 ml of MOM. 2. If no results in 16 hours give 2nd dose of 30 ml of MOM...".</p> <p>R26 had a care plan, dated 12/17/13, entitled, "Potential for alteration in Bowel related to</p> | F 309 | <p>F 309</p> <p>proper facility protocol has been followed.</p> <p>3.b. The facility failed to follow the recommended renal diet restriction by providing orange juice to a resident on a renal diet. The dietitian will in-service the dietary staff on the renal diet restrictions. No other residents were on a renal diet. The lead staff member of the dietary staff will inspect all renal diet breakfast trays to ensure that orange juice is not on the trays.</p> <p>4.a. Audit will be done of the daily report twice a week by the DON/ Designee x2 weeks until 100% compliance, then weekly x2 weeks until 100%, then monthly x2 months until 100%. The results will be present to QAPI to determine further monitoring.</p> <p>4.b. The dietary director/designee will audit the breakfast tray</p> <p>delivery twice a week x 2 weeks until 100% then weekly x2 weeks then monthly x2 months until 100%. The results will be present to QAPI to determine further monitoring.</p> | 12-2-15 |

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| F 309 | <p>Continued From page 29</p> <p>Parkinson's Disease, Medications, Constipation" with approaches that included: "Administer medication per...order...Monitor for and document q shift for BM's; Monitor for s/s constipation q shift, i.e...abd (abdominal) distention, abd pain/ cramps, n/v, diarrhea, decreased po intake".</p> <p>Review of R26's Care Tracker bowel records from 8/23/15 through 9/22/15 revealed that R26 had no BM's from 8/29/15 shift 1 through 9/2/15 shift 2; (14 shifts), from 9/3/15 shift 1 through 9/10/15 shift shift 1 (22 shifts); and from 9/16/15 shift 1 through 9/19/15 shift 2 (11 shifts).</p> <p>Review of R26's August and September 2015 Physician's Order Sheets stated, "Milk of Magnesia...30 ml by mouth daily if no bowel movement in 3 days".</p> <p>R26's August and September 2015 MARs lacked evidence that R26 was administered MOM as per R26's care plan, physician's orders and the facility's bowel protocol.</p> <p>Review of R26's NN's revealed that the last nurse's note was written on 8/11/15. There was no evidence of bowel assessments or MOM administered as ordered.</p> <p>During an interview on 9/22/15 at 3:28 PM, E3 (ADON) stated there was no minimum requirement for NN's on Long Term Care residents, "charting is done by exception".</p> <p>During an interview on 9/22/2015 at 3:53 PM, findings were discussed with E2 and E3. E2 confirmed there was no evidence that the BM protocol was followed, no evidence that MOM was administered as ordered and per the plan of</p> | F 309 | | 12-2-15 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/23/2015 |
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| NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810 | |
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| F 309 | Continued From page 30 care and there was no evidence of any NN after 8 /11/15 to indicate if any assessments were done per the bowel protocol when R26 failed to have a BM in more than 3 days. | F 309 | F314 1.a. Resident 62 remains stable in the facility wound has been evaluated by MD with appropriate treatments ordered. R62 placed on a turning and repositioning program. The program has been added to the TAR. Nurses will document that R62 has been repositioned. | 12-2-15 |
| F 314 SS=G | Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) on 9/23/15 during the exit conference at approximately 4:20 PM. 483.25(c) TREATMENT/SVCS TO PREVENT/ HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R62) out of 34 Stage 2 sampled residents, the facility failed to provide the necessary treatment and services to prevent pressure ulcers from developing. The facility failed to: consistently implement a turning and repositioning program for a resident who was identified at risk for developing pressure ulcers; failed to identify an area of pressure until it presented as DTI in evolution; and failed to consistently follow policy and procedure and the plan of care after the DTI was identified. Findings include: | F 314 | 1.b. Resident R62 had a full body skin check to determine any further breakdown. There was no further skin break down on R62. 1.c. Dietitian evaluated R62 nutritional needs and no further interventions were needed. 1.d. R62 weekly wound notes were reviewed and are completed in the timeframe as per policy. 2.a. All residents identified as moderate to high risk by their Braden risk score are impacted by this practice. A review of all residents Braden risk scores will be conducted by the DON/Designee to identify residents at moderate to high risk for pressure ulcers. Identified residents will be reviewed at IDT meeting to determine if treatments and care plan interventions are appropriate. 2.b. All residents have the potential to be effected by this practice. An audit of all residents' weekly skin sheets will be completed to identify any missing | 12-2-15 |

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| F 314 | Continued From page 31 The facility policy titled "Skin and Wound Management Program Overview," revision date 3/10/15, stated, "1.0 Purpose...The resident does not develop pressure ulcers unless clinically unavoidable and the facility provides care and services to: Promote the prevention of pressure ulcer development...3.0 Procedure...all residents will be screened to determine their risk of development of pressure ulcers using the Braden Scale Risk Assessment...2. Any resident identified at risk for development of pressure ulcers, as indicated by Braden Scale Risk Assessment score of 18 or less, will have the Initial Plan of Care initiated by the admitting nurse, to minimize the risk of developing a pressure ulcer...4. A visual 'head to toe' skin review will be performed at least weekly by a Certified Nursing Assistant (C.N.A.)...Results will be verified and documented by a licensed nurse... Whenever a new wound is identified, a licensed nurse will complete a comprehensive evaluation, and document the findings on the Initial Wound Review Form...7. ALL WOUNDS will be monitored daily, as required by a licensed nurse, with documentation on the Daily Wound Review form...8. All wounds will be monitored at least weekly by a licensed nurse during wound rounds, with documentation on the Weekly Wound Progress Review form...14...For a pressure ulcer to be considered 'unavoidable', the following criteria must be met:..c. Implementation and defined interventions consistent with resident needs and standards of practice..." The User-Service Manual Joerns Support Surface Calc APM, 2010, states, "...Optional Accessories...Integrated Calc Rails risk management side air bolsters--two-inch side | F 314 | F314 documentation by DON/designee. Any resident identified will have a full body skin check to identify any skin issues. 2.c. All residents receiving supplements are at risk for this practice. Residents receiving supplements will have their MAR's reviewed for missing documentation by DON/designee. The residents identified will be evaluated by the dietitian for further recommendations. 2.d. All residents are being seen on weekly wound rounds are at risk from this practice. A review of the past monthly weekly wound round notes to determine if any documentation falls outside the timeframe. 3.a. The facility allegedly failed to identify a pressure area before it evolved into DTI. Residents identified as moderate to high risk for pressure ulcers will have a turning and repositioning program developed to meet their individual needs. Nursing staff will be provided with educational resources on the prevention and early detection of pressure ulcers. Admission and quarterly Braden risk assessments will be reviewed by DON/Designee to identify any resident changes. Those residents | 12-2-15 | |

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| F 314 | <p>Continued From page 32</p> <p>bolsters that inflate on both sides of the patient along the mattress edge to provide additional support and to provide a gentle reminder to the patient that they are near the edge of the mattress...Nursing Procedures...Minimal amount of padding between the patient and bed for optimum performance...General Repositioning: Patients should be turned and repositioned per individual turning schedule or per facility policy..."</p> <p>The NPUAP Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, Second Edition published 2014, states "...Frequent assessment of the individual's skin condition will help to identify the early signs of pressure damage and, as such, her/his tolerance of the planned repositioning schedule. If changes in skin condition should occur, the repositioning care plan needs to be re-evaluated...Additional Recommendations for Individuals with Existing Pressure Ulcers: 1. Do not position an individual directly on a pressure ulcer. 1.1 Position the individual off area(s) of suspected deep tissue injury with intact skin...Pressure reduces perfusion to injured tissues. Continued pressure on an existing pressure ulcer will delay healing and may cause additional deterioration. 2. Continue to turn and reposition the individual regardless of the support surface in use...No support surface provides complete pressure relief ..."</p> <p>R62 was admitted to the facility on 9/27/13 with diagnoses that included a history of CVA and dementia.</p> <p>R62 had a care plan, developed on 10/8/13 and last revised on 9/8/15, for the problem, "Potential for alteration in skin integrity related to decreased</p> | F 314 | <p>F314</p> <p>will be discussed at IDT meeting for appropriate interventions and care plan. Licensed nursing staff will be in serviced by DON/ Designee to on the procedure for residents identified as at risk for skin break down; turning/repositioning program and use of Braden scale. 3.b. Facility failed to document the completion of weekly skin checks. The supervisors will review all skin checks that are due on their shift ensure the documentation has occurred. The DON/designee will in-service licensed nurses and supervisor on the weekly documentation of skin checks. 3.c. Facility failed to document the consumption of a nutritional supplement. Licensed nurses will exchange MAR's with other licensed nurses for review to ensure appropriate document of nutritional supplement. DON/designee will in-service licensed nurses on the exchange of MAR 3.d. The facility failed to meet the timeframe of weekly wound notes due to the wound nurse being on vacation. The facility will have a back-up nurse for when the wound nurse is not available. The DON/designee will in-service the wound nurse to ensure the nursing</p> | 12-2-15 | |

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| F 314 | <p>Continued From page 33</p> <p>mobility, incontinence with brief use, fluctuating intake, restlessness, medications." The care plan's approaches included to document abnormal findings and notify MD/RP, encourage/assist to T&R q round and prn, mattress and W/C cushion -see care card, offload heels as needed, and weekly skin checks/daily observation of skin by direct care staff.</p> <p>The clinical record revealed a physician's order, dated 3/30/15, for R62 to be on Comfort Care. A second physician's order, dated 6/4/15, stated that weights were no longer to be obtained.</p> <p>A Braden Scale, dated 6/6/15, revealed R62 scored "15" identifying him as being at risk for developing a PU.</p> <p>The annual MDS assessment, dated 6/12/15, stated R62's daily decision making skills were severely impaired; he required extensive assist of one staff for bed mobility, dressing, toilet use and hygiene, and extensive assist of two (2) staff for transfers. The MDS stated R62 was at risk of developing a PU, he had no current or unhealed PU, a pressure reducing device was in use for bed and chair, and he was not on a T&R program.</p> <p>Review of the Weekly Skin Check sheets revealed that on 8/4/15, 8/18/15 and 8/25/15 there were "no open areas present." There was no evidence that a weekly skin check was completed on 8/11/15. The facility failed to follow R62's plan of care and failed to provide the necessary services.</p> <p>An undated CNA Kardex/care card did not list the use of any pressure reducing device for the bed</p> | F 314 | <p>F 314</p> <p>leadership know of their unable to complete weekly wound notes.</p> <p>4.a. Braden risk evaluations will be audited weekly and be reviewed By DON/Designee for completeness, accuracy and identifying changes x4 weeks until 100% compliance, then monthly x 2 months until 100% compliance. . Random weekly audits will be performed for residents who are having turning/ repositioning programs x 4 weeks until 100% compliance then monthly x 2 months until 100% compliance. Results will be brought to QAPI to determine further monitoring.</p> <p>4.b Weekly audits of residents receiving weekly skin checks X 4 weeks until 100% compliance, then monthly audits X 2 months until 100% compliance. Results would be brought to QAPI to determine further monitoring</p> <p>4.c. Weekly random audits of 10% residents receiving nutritional supplements x2 weeks until 100% compliance, monthly x2 months until 100% compliant. Results will be brought to QAPI to determine further monitoring.</p> <p>4.d. Weekly audit of weekly wound note to monitor for timeliness x2 weeks until 100% then monthly x2 months until 100%. Results will be presented to QAPI to determine further monitoring.</p> | 12-2-15 | |

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| F 314 | <p>Continued From page 34</p> <p>and/or chair and stated R62 was "Independent" for bed mobility. Additionally, the Kardex did not identify any T&R schedule, nor did it mention a need to offload R62's heels.</p> <p>Review of the electronic ADL Flow Sheet Log from 8/20/15 through 9/3/15 revealed R62 required extensive assist to total dependence on one (1) to two (2) staff for bed mobility.</p> <p>Review of the electronic "Turn and Reposition Detail Report" from 8/20/15 through 9/3/15 revealed that on 66 occasions when charting was done, on only 11 occasions was it documented that T&R was completed. All other entries stated, "Activity Not Required."</p> <p>Review of the electronic CNA ADL sheet and the TAR from 8/1/15 through 9/3/15 lacked evidence of any offloading of R62's heels and/or feet.</p> <p>The Behavior/Intervention Monthly Flow Record, which monitored R62's combative behavior with care, revealed no evidence of combative behavior from 8/22/15 through 9/3/15. Additionally, review of NN's from 8/11/15 through 9/3/15 revealed only one (1) documented episode of combative behavior and refusal of care on 8/11/15 at 3:30 AM.</p> <p>Review of the clinical record revealed an order, dated 8/31/15, for R62 to receive SLP services for difficulty swallowing. A SLP evaluation, dated 9/1/15 stated R62 was "referred to therapy due to reports from nursing of swallowing difficulties during meals for 2 weeks...presents with weight loss, persistent coughing...Patient will be downgraded to mechanical soft (diet) and honey thick liquids (honey consistency)..."</p> | F 314 | | 12-2-15 | |

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| F 314 | Continued From page 35 An order, dated 9/1/15, stated for R62 to receive Ensure plus 120 cc twice a day due to decreased meal intakes. Review of the MAR from 9/2/15 through 9/9/15 revealed R62 was accepting 50-100% of the Ensure twice daily, except on 9/8/15 when the 8:00 AM dose was not signed off as given. A Weekly Skin Check, dated 9/1/15, noted redness on the buttock area. A NN, dated 9/3/15 and timed 6:45 PM, stated, "Resident noted c redness on L ankle resulting from pressure when laying in bed. Tx order written to apply skin prep on B/L ankles and also to offload BLLE while in bed. Supervisor notified." An Initial Wound Evaluation, dated 9/3/15, stated that a wound was identified on the lateral ankle (did not state right or left), was a suspected DTI and measured 1.5 cm (length) by 1.5 cm (width) with no depth. The sheet also stated that skin prep was ordered, a pressure relief mattress was in place, and the goal of treatment was improvement of the wound. Physician's orders, dated 9/3/15, stated "low air loss mattress; skin prep to L lateral ankle q shift; turn and reposition q 2 hours; offload bilateral heels with pillow when in bed as tolerated, and skin prep to bilateral heels q shift while in bed as tolerated." Review of the TAR from 9/3/15 through 9/23/15 revealed staff signed off that R62's heels were offloaded while in bed as tolerated. On 9/4/15, a physician's order stated, "No shoes | F 314 | | 12-2-15 | |

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| F 314 | <p>Continued From page 36 to be worn."</p> <p>A physician's order was written on 9/4/15 to obtain a Prealbumin level. Results of this blood test revealed R62's value was below normal at 14.1 (normal limits: 18.0-38.0 MG/DL).</p> <p>On 9/4/15 a quarterly Data Collection Tool was completed which stated R62 was dependent on staff for all ADLs, including bed mobility.</p> <p>A physician's progress note, dated 9/4/15, stated "Asked to see pt to F/U +...debility. + new wounds . (Decreased) PO intake...DTI LLE. PT screen... add ensure, comfort care..."</p> <p>A nurse's note, dated 9/5/15 and timed 6:45 PM, stated "On 9/3/15, during routine rounds, I noted a reddened area on residents L ankle. Resident was laying in bed. At assessment, determined the redness was from pressure on L ankle. Site is circular in shape with a diameter of 1.5 cm. Skin prep applied and BLE elevated. Supervisor on duty was notified and also did an assessment..."</p> <p>The Weekly Wound Progress Note, dated 9/7/15, stated the wound was located on the L lateral malleolus, was a DTI and measured 1.9 cm by 1.4 cm with no depth. The summary stated, "...skin prep per MD order...on low air loss mattress, (no) shoes. B/L heels offloaded in bed as tolerated..."</p> <p>A Weekly Skin Check, dated 9/8/15, failed to identify the DTI on the L lateral malleolus.</p> <p>On 9/8/15 the potential for alteration in skin integrity care plan was revised to include the approaches "skin prep to bilateral heels and lateral ankles, low air loss mattress and turn and</p> | F 314 | | 12-2-15 |

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| F 314 | <p>Continued From page 37 reposition as indicated."</p> <p>A Physical Therapy Plan of Care, dated 9/9/15, stated that according to R62's current level of function, he required moderate assistance of two staff for rolling side to side while in bed and that he had impaired sensation to the BLLEs.</p> <p>A physician's order, dated 9/9/15, stated to increase the Ensure to four times a day and to add Prostat 30 ml twice a day.</p> <p>A 9/9/15 significant change MDS assessment stated R62's daily decision making skills were severely impaired, he required extensive assist of two (2) staff for bed mobility and currently had a suspected DTI in evolution.</p> <p>The Weekly Wound Progress Note, dated 9/11/15, stated the wound measured 2.0 cm by 1.4 cm with no depth. The summary stated, "Wound L lateral malleolus (sic) intact, 100% purple DTI c blister formation noted. N/O to begin today for Marathon liquid Q 3 days..B/L heels intact and offloaded c pillows..."</p> <p>On 9/11/15 a care plan for Pressure ulcer DTI left lateral malleolus was developed. Approaches included "keep pressure off area(s) as able."</p> <p>Review of the 9/14/15 TAR lacked a signature signifying that Marathon liquid was applied as ordered.</p> <p>The 9/15/15 Weekly Skin Check noted "pressure area unopened" on the L lateral malleolus.</p> <p>The 9/19/15 TAR lacked evidence of Ensure and Prostat being given as ordered on the 7 AM to 3</p> | F 314 | | 12-2-15 | |

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| F 314 | <p>Continued From page 38 PM shift (2 doses Ensure, one dose Prostat).</p> <p>The 9/22/15 Weekly Skin Check noted "dark area " on the L lateral malleolus.</p> <p>The facility did not complete the next Weekly Wound Progress Note until 9/23/15, 12 days later, instead of weekly, as per the care plan and facility policy. The 9/23/15 Weekly Wound Progress note stated to continue with Marathon liquid per MD order, offload heels as tolerated, continue on low air loss mattress and that the DTI measured 1.0 cm by 0.5 cm with no depth.</p> <p>The following observations/Interviews were made: - 9/17/15 at 8:22 AM - lying on bed on back sleeping, both heels directly on mattress, not offloaded. - 9/17/15 approximately 9:15 AM - lying on back, head of bed at 45 degrees, heels directly on mattress, not offloaded. - 9/17/15 at 11:35 AM - lying in bed on back, heels in direct contact with mattress with left side of foot in contact with the bolster part of the mattress and both great toes are pressed up against the bed's footboard. - 9/22/15 at 4:23 PM - lying in bed slightly turned to left side, head of bed raised at 45 degrees, both feet on pillow with the left malleolus in direct contact with the pillow; observed moving right foot - 9/23/15 at 8:39 AM - observed both feet with E 22 (LPN); has pillow under lower legs, but heels are in direct contact with mattress, E22 confirmed heels were not offloaded and stated "yesterday he had two pillows to offload." -9/23/15 approximately 11:00 AM - In an interview with E23 (RN/WCC) when asked why the weekly wound progress note was not done from 9/11/15</p> | F 314 | | 12-2-15 |
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| F 314 | <p>Continued From page 39</p> <p>until 9/23/15, E23 stated she was on vacation last week and "someone was supposed to be assigned to do it."</p> <p>-9/23/15 approximately 1:00 PM - observed E3 (ADON) and E23 in R62's room; spoke with them regarding the lack of offloading of the heels. E3 stated that there was no need to offload R62's heels as he was on a low air loss mattress.</p> <p>During an interview on 9/23/15 at approximately 2:30 PM, findings were reviewed with E2 (DON), E3, and E16 (Regional Nurse Consultant). E2 stated that the DTI was caused by R62's shoes, that they found it because they were checking the resident's skin and they developed interventions right away. E3 stated that a low air loss mattress was offloading and she had been a wound care nurse previously. E2 then shared the facility's Unavoidable Pressure Ulcer Quality Improvement Tool, dated 9/7/15. This tool stated the following:</p> <ul style="list-style-type: none"> - R62's risk factors included "impaired/decreased mobility and decreased functional ability," and "Resident refusal of some aspects of care or treatment." - "The following interventions were initiated to address the resident's risk factors prior to development of a pressure ulcer: T&R, pressure reducing mattress, 2 person assist in bed; - Narrative Summary: appears that resident shoes caused alteration to ankle. Alteration very consistent with where shoes pressed. No shoes to be worn currently, non skid socks, Tx and low air loss mattress." <p>E2 provided R62's shoes for observation to the surveyor. They were Air Monarch sneakers. The inner lining on the left lateral sneakers was observed with a soft cushioned lining.</p> <p>Although R62 was identified as being at risk for</p> | F 314 | | | 2-2-15 |

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| F 314 | Continued From page 40 developing pressure ulcers, the facility failed to consistently follow a turning and positioning schedule for this resident who required assistance from staff for bed mobility and they failed to offload his heels according to the care plan. There was no evidence that R62 refused these interventions for the two weeks prior to identification of the DTI. Despite the care plan approach for daily observations of skin by direct care staff, R62's PU was not identified until it was a DTI in evolution. The facility failed to complete weekly, accurate skin checks, they failed to administer supplements as ordered, and they failed to complete a Weekly Wound Progress Note. Additionally, the facility failed to correctly offload the left lateral malleolus after the DTI was identified. | F 314 | F315 1. Resident 12 and resident 7 remain stable and continue to reside at the facility. 3 day voiding diary and bladder incontinence assessment completed for both residents. Care plans developed and proper interventions in place to prevent UTI's and to restore as much normal bladder function as possible. 2. All residents who are incontinent of bladder are at risk from this practice. All residents who have been identified as incontinent of bladder will have a 3 day voiding diary completed. The DON/ Designee will review the diary and incontinence assessment for completeness and accuracy. The care plans will be reviewed and interventions discussed at IDT meeting. | P-2-15 |
| F 315 SS=G | Findings were reviewed with E1 (ED), E2 and E3 (ADON) on 9/23/15 during the exit conference at approximately 4:20 PM. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by | F 315 | 3. The facility allegedly failed to ensure that the 3 day voiding diary and incontinence assessment were completed and accurate. All new and re admissions will have a 3 day voiding diary completed. Once the 3 day voiding diary is completed the results will be reviewed at IDT meeting to determine need for further assessment and develop a care plan with appropriate interventions. MDS coordinator will communicate any changes in | P-2-15 |

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| F 315 | <p>Continued From page 41</p> <p>Based on clinical record reviews, interviews, and review of facility documentation, it was determined that the facility failed to ensure that 2 (R7 and R12) out of 34 Stage 2 sampled residents, who were incontinent of bladder received the appropriate treatment and services to prevent UTIs and to restore as much normal bladder function as possible.</p> <p>For R12, the facility failed to:</p> <ul style="list-style-type: none"> - assess R12's urinary status twice, upon admission and readmission; - Failed to develop a care plan that identified potential causes for a UTI after R12's hospitalization; - Failed to implement a 3 day voiding diary on admission, readmission, and when there was a decline in R12's urinary status; - Failed to comprehensively assess R12's bladder incontinence on admission and after the 8/12/15 quarterly MDS revealed a decline in bladder function; - Failed to identify that R12's bladder function was not recorded by the CNA's 6 times in July; - Failed to identify, reassess and respond to R12's increase in urinary incontinence for approximately five (5) months (May 14, 2015 through September 17, 2015). <p>For R7, the facility failed to:</p> <ul style="list-style-type: none"> - accurately and comprehensively assess R7's urinary continence status upon admission; - Failed to complete a 3-day voiding diary; - Failed to develop an individualized toileting plan; - Failed to identify a progressive decline in R7's urinary status; - Failed to act accordingly and attempt to restore as much normal bladder function; | F 315 | <p>F315</p> <p>resident's urinary incontinence when MDS assessments are completed to the DON/Designee. The DON/ Designee will have a 3 Day voiding diary completed and review the incontinence assessment for completeness and accuracy. Voiding diary, Incontinence assessment and care plans will be reviewed at IDT meeting to identify any trends/patterns or opportunities to restore normal bladder function as possible. The DON/ designee will in service the nursing staff on the 3 day voiding diary and incontinence assessment procedure. The RNAC/MDS coordinator will be in serviced by the DON/Designee to report urinary continence decline to the DON/Designee.</p> <p>4. The DON/Designee will audit all new and re admissions for 3 day voiding diary and incontinent assessment for accuracy and completeness weekly x 4 weeks until 100% compliance then a random audit at 10% monthly x 2 months until 100% compliance. Results will be brought to QAPI to determine further monitoring</p> | 12-2-15 | |

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| F 315 | Continued From page 42 - Failed to reassess R7's urinary status that progressed to always incontinent. Findings include: The facility policy entitled "Bladder Elimination Assessment," revised 6/30/06, stated, "Purpose To ensure that each resident who is Incontinent of urine is identified, assessed and provided appropriate treatment and services through an interdisciplinary approach, to achieve or maintain as much normal urinary function as possible, and avoid urinary tract infections... Each resident will be assessed on admission to determine bladder continence or incontinence. If it is determined that the resident is incontinent an in-depth assessment will be completed using the Bladder Incontinence Evaluation Form. The resident will be re-assessed if there is a significant change and annually. A 3-day bowel and bladder flow sheet will be completed on each incontinent resident. Utilizing the Evaluation Form and the Flow Sheet, the recommendation will be made for a retraining program if appropriate... If the resident is not recommended for a retraining program an appropriate care plan will be developed for that resident... Procedure... 2. If resident is determined to be incontinent on the Admission Nursing Assessment, the nurse will gather more specific information by completing the Bladder Incontinence Assessment form... and begin a 3-Day Bowel and Bladder Flow Sheet... The nurse will review the data from the Bladder Incontinence Assessment and 3-Day Bowel/ Bladder Flow Sheet to determine if the resident is a candidate for a re-training program. If it is determined that the resident is an appropriate candidate for a retraining program, the resident will be referred to the Restorative Program. 4. If the resident is not a candidate for a re-training | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 43</p> <p>program..., care planning for the resident should take into account the individual findings of the assessments. 5. Re-assessment should occur with any significant change, annually or as deemed necessary..."</p> <p>1. In R12's thinned records, a hospital progress note, dated 5/9/15, stated, "Pt admitted with UTI and AMS..."</p> <p>Interagency Nursing Communication Record completed by the hospital and dated 5/14/15, listed R12 with diagnosis of a UTI.</p> <p>R12 was admitted to the facility on 5/14/15 with diagnoses that included dementia and UTI.</p> <p>Review of the facility's documents for the month of May revealed the following:</p> <p>Data Collection Tool, dated 5/14/15, completed on admission, noted the resident to be lethargic, with poor decision making, and the area of bladder function was blank.</p> <p>Physician's Admission H&P, dated 5/15/15, stated R12 had a history of a UTI while in the ICU in the hospital.</p> <p>A four page Bladder Incontinence Assessment, undated, was blank, except for R12's first and last name, the attending physician, and the room number. R12's assessment had no information regarding the resident's current status, bladder status, potential causes of incontinence, exams, summary (part of the assessment done after review of the Bladder Incontinence Assessment and the 3-Day B&B Flow Sheet are completed) and whether R12 was a candidate for a retraining</p> | F 315 | | 12-2-15 |

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| F 315 | <p>Continued From page 44 program.</p> <p>There was lack of evidence in the clinical record that upon admission a bladder assessment and a 3-Day B/B Flow Sheet (3-Day voiding diary) was done.</p> <p>NN's from 5/15/15 through 5/17/15 documented that R12 was on daily skilled nursing services S/P UTI, alert with confusion, able to make needs known, incontinent of B&B, and "bladder training N/A".</p> <p>The admission MDS assessment, dated 5/21/15, stated R12 was moderately impaired (decisions poor; cues/supervision required). The same MDS stated R12 was a one person, extensive assist for transfers and toilet use, and she was frequently incontinent. The MDS listed R12 with a diagnosis of UTI within the last 30 days and she received a diuretic during the seven (7) day review time period (5/15/15 through 5/21/15). The CAA Summary, dated 5/21/15, triggered ADLs Functional Status/Rehabilitation Potential as a potential problem area and it was checked off to proceed with care planning. The CAA Summary Report, dated 5/21/15, stated, "She was admitted s/p hospitalization for change in mental status, UTI...She has a hx of...UTIs..." The CAA Summary also triggered for urinary incontinence as a potential problem area and it was checked off to proceed with care planning. The CAA Summary Report stated, "She was admitted s/p UTI. She has B/B incontinence. She is at risk for further UTI and skin breakdown."</p> <p>NN's from 5/22/15 through 5/23/15 documented that R12 was on daily skilled nursing services S/P</p> | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 45</p> <p>UTI, alert with confusion, able to make needs known, incontinent of B&B, and "bladder training N/A".</p> <p>Although R12 came into the facility with a diagnosis of a UTI, eleven days later, on 5/25/15 a urinary incontinence care plan was developed. Approaches included: incontinence care as needed after each episode of incontinence; monitor for increased episodes of incontinence; and one person assistance with toileting. A care plan approach was yellowed out (discontinued) that stated, "Toilet/check/change resident upon rising in AM, before & after meals, at bedtime and every 2 hours during the night". Handwritten and undated was an approach to "Check and change q round and PRN." It is unclear when the approach to "check and change q round (usually every 2 hours) and PRN" was implemented, as it was undated.</p> <p>Physician's Progress note, dated 5/26/15, stated was asked to see R12 secondary to drowsiness and wrote to check a urine culture. Review of the May MAR indicated that an order was written to collect urine for U/A and C/S on 5/26/15. On 5/30/15 another order was written for R12 to start an antibiotic for 7 days.</p> <p>Document review for the month of June revealed the following:</p> <p>Physician's Progress note, dated 6/1/15, stated the chief complaint of the visit was for a UTI, which developed in the facility, and that R12 was to continue Macrobid (antibiotic/ABT) for UTI.</p> <p>Review of the June MAR indicated R12 received her ABT until 6/6/15 as ordered.</p> | F 315 | | 12-2-15 | |

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| F 315 | Continued From page 46 Document review for the month of July revealed the following: Review of the Bowel and Bladder Detailed Entry Reports (completed by CNAs) from 7/1/15 through 7/31/15, lacked evidence that the toileting schedule was being followed. Documentation was only completed once per shift. Additionally, there were various responses such as; "checking and changing pads during rounds," and "resident asked to be toileted - used bathroom/bedpan." This report also revealed the following: - 7/2/15 from 2:09 AM to 10:00 PM (no evidence R12 was toileted for about 20 hours); - 7/3/15 from 7:27 AM to 10:57 PM (no evidence R12 was toileted for over 15 hours); - 7/4/15 from 10:59 PM to 7/5/15 1:23 PM (no evidence R12 was toileted for over 13 hours); - 7/20/15 from 1:04 PM to 7/21/15 12:17 AM (no evidence R12 was toileted for over 11 hours); and - 7/27/15 from 10:17 PM to 7/28/15 2:04 PM (no evidence R12 was toileted for over 15 hours). An SBAR Communication Form, dated 7/12/15, stated, "R12 had a decreased level of consciousness, increased confusion or disorientation, decreased mobility, needs more assistance with ADLs, weakness (general), rapid breathing...Transfer to the hospital (non-emergency)...Resident didn't eat dinner secondary to N/V with decreased LOC, increased HR and temp...yet continues with change in MS, increased temp...". A Physician's Order, dated 7/12/15, instructed staff to send R12 to the ER for evaluation based on diagnoses of change in mental status, increased HR, decreased oxygen, and increased | F 315 | | 7-2-15 | |

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| F 315 | <p>Continued From page 47 temperature.</p> <p>The Hospital H&P, dated 7/12/15, stated R12 was admitted for AMS, her niece noticed the change of mental status at the facility. At that time R12 had a temperature of 101.5 (fever) and was hypoxic. R12 had similar symptoms with a previous UTI, so the facility was "concerned" and sent her for an evaluation. She was treated for "sepsis" and given IV antibiotics and fluids. The document also stated that R12 had a UTI and PNA, an elevated white blood cell count (indicative of an infection), and AMS that was likely due to infection.</p> <p>A Hospital Discharge Summary, dated 7/15/15, stated that R12 was admitted because of AMS, she was initially treated for possible UTI and chest X-ray findings were + for PNA.</p> <p>The Data Collection Tool, dated 7/15/15, completed on readmission from the hospital, listed UTI and PNA as current diagnoses and noted R12 was incontinent of urine, pads/briefs were used and the resident was dependent for toilet use.</p> <p>A Bladder Incontinence Assessment, dated 7/15/15, stated R12 was confused, wheelchair bound and she needed extensive assistance for ADLs. The assessment listed that R12 had no apparent voiding pattern, unable to determine onset of incontinence, had multiple daily episodes of little or no control and her perception of need to void was absent. R12's assessment had no information regarding the resident's potential causes of incontinence, exams, summary (part of the assessment done after review of the Bladder Incontinence Assessment and the 3-Day B&B</p> | F 315 | | 12-215 | |

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| F 315 | <p>Continued From page 48 Flow Sheet are completed) and whether R12 was a candidate for a retraining program.</p> <p>The Physician's Admisslon H&P, dated 7/15/15, stated, "...S/P UTI of sepsis...(sic)".</p> <p>NN's from 7/15/15 through 7/17/15 revealed: - 7/15/15 at 10:00 PM, "Received...at 7:15 PM... Has a dx of UTI, PNA...Incontinent of B&B...". - R12 was alert with confusion, able to verbalize needs, incontinent of B&B, requires asslst X1 for ADLs and transfers and continues on ABT for PNA and UTI.</p> <p>Physician's Progress Admit Note, dated 7/16/15, stated S/P hospitalization secondary to change of mental status and fever. The plan listed was to complete the ABT for her PNA and UTI.</p> <p>A 3-Day B/B Flow Sheet was done from 7/16/15 through 7/18/15, the front of the document was filled out, but the back portion was not, It did not capture or identify any episodes of urinary incontinence. There was no evidence that data was analyzed in order to develop an individualized toileting schedule for R12.</p> <p>Review of the July MAR indicated R12 received her ABT until 7/20/15 as ordered.</p> <p>Document review for the month of August revealed the following:</p> <p>The Data Collection Tool, dated 8/10/15, completed as a quarterly assessment, listed UTI ... and PNA as current diagnoses and noted R12 was incontinent of urine, pads/briefs were used and the resident needed physical assistance for toilet use.</p> | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 49</p> <p>A Bladder Incontinence Assessment, dated 8/10/15, stated R12 was confused, wheelchair bound and needed extensive assistance for ADLs and unable to determine onset of Incontinence. R12's assessment had no information regarding the resident's current status, bladder status, potential causes of Incontinence, exams, summary (part of the assessment done after review of the Bladder Incontinence Assessment and the 3-Day B&B Flow Sheet are completed - stated, "Resident is incontinent of bowel and bladder") and whether R 12 was a candidate for a retraining program.</p> <p>R12's Quarterly MDS assessment, dated 8/12/15, stated R12 was severely impaired for decision making and continued to be a one person, extensive assist for transfers and toilet use. R12 was now coded as always incontinent, and she was not on a toileting program. This is a decline in continence from the 5/21/15 MDS when R12 was frequently incontinent. The same MDS listed R12 with a diagnosis of UTI within the last 30 days and she received a diuretic during the seven (7) day review time period (8/6/15 through 8/12/15).</p> <p>Although the urinary incontinence care plan had a handwritten note on the bottom of the page that it was reviewed and revised on 8/14/15, the facility failed to capture that R12 had two UTI's, one of which she was hospitalized for, while in the facility. The facility failed to revise the care plan and failed to incorporate new interventions.</p> <p>Review of the clinical record revealed that an undated CNA resident care card (Kardex) indicated that R12 was incontinent of bladder and needed one person asst. There was no</p> | F 315 | | 2-2-15 | |

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| F 315 | <p>Continued From page 50</p> <p>evidence that a 3 day voiding diary was completed and analyzed in order to establish an individualized toileting schedule for R12.</p> <p>Review of the electronic "Resident Bowel and Bladder by Shift Chart," completed by CNAs that capture if the resident is continent or incontinent of bladder, for May 2015 through September 2015 revealed the following:</p> <ul style="list-style-type: none"> - 5/14/15 through 5/31/15 consisted of a total of 52 shifts during which R12 was incontinent on 37 out of the 52 shifts (71%); - 6/1/15 through 6/30/15 consisted of a total of 90 shifts during which R12 was incontinent on 69 out of the 90 shifts (77%); - 7/1/14 through 7/31/14 consisted of a total of 83 shifts during which R12 was incontinent on 73 out of the 83 shifts (88%). In the month of July, R12 was hospitalized from 7/12/15 to 7/15/15. In addition there were 6 shifts (7/2/15; 7/3/15; 7/5/15; 7/6/15; 7/20/15; 7/28/15) that lacked evidence that R12 was toileted or incontinence care was given, two of those shifts were after R12's hospitalization for a UTI. - 8/1/15 through 8/31/15 consisted of a total of 93 shifts during which R12 was incontinent on 84 out of the 93 shifts (90%). - 9/1/15 through 9/17/15 consisted of a total of 51 shifts during which R12 was incontinent on 46 out of the 51 shifts (90%). <p>The following information was obtained by interviews with facility employees:</p> | F 315 | | 12-2-15 |

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| F 315 | <p>Continued From page 51</p> <p>- 9/21/15 at 11:25 AM E18 (RN) stated It was facility practice for the receiving nurse to fill out assessment forms which included the Bladder Incontinence Assessment on new residents and ones returning from the hospital that were out for > a day. The CNAs were responsible for doing the 3-Day B/B Flow Sheet, once completed, they gave it to the charge nurse (UM). E18 further stated that the nurses do not evaluate the 3-day voiding dairy, they are only responsible to complete the front of the assessment. E18 stated If a resident was on a toileting program, then Caretracker would let the CNAs know.</p> <p>- 9/21/15 at 11:32 AM E19 (CNA) stated that everytime we toilet someone, we have to chart it in Caretracker. When residents first arrive, a 3-day voiding diary is completed and chart Y (yes) or N (no) to capture if they are continent or incontinent. E19 stated this charting is done on paper, not on Caretracker, then once the front is completed, it is given to the medication nurse, then the medication nurse gives to the supervisor (UM). E19 stated the 3-day voiding diary "showed what the resident really needed or how often they needed toileted." E19 stated that Caretracker does not capture when to toilet someone, we are verbally told in report if someone is on a toileting program. Caretracker does not show the amount of times it was charted in, instead an event is highlighted in yellow to alert you that an event was not charted. E19 stated, for example, once Bladder Activity is charted on, the alert light goes off. With regard to R12, E19 stated she was not on a toileting program and R12 verbalized when she needed to go. R12 was incontinent at times and stated when she wanted to go to the bathroom, but when checked she was already wet.</p> | F 315 | | | 12-2-15 |

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| F 315 | <p>Continued From page 52</p> <p>- 9/22/15 at 9:43 AM E20 (RN,UM) stated once the Interagency document was received, the UM entered all the orders. Medication nurses were responsible for all the assessments, including the Bladder Incontinence Sheet and the the 3-day voiding dairy. E20 stated, if the resident was known to be incontinent by either the Interagency document, family interview, or upon checking the resident and finding them to be wet, the unit nurse would initiate the 3-day voiding diary. When asked who reviewed the dairy, E20 stated she was unsure, she had never been given the document to review in the year she has been there. Once reviewed, a care plan toileting program was initiated by the IDT team, compromised of the MDS coordinator, DON, and ADON. E20 then stated that the Kardex was updated in the daily clinical meetings for the CNAs to know the plan. She was unsure if Caretracker was reflective of what was in the Kardex.</p> <p>- 9/22/15 at 10:30 AM E21 (LPN) stated when a resident first arrives, the unit nurses are responsible for full head to toe assessments and they had to fill out the Bladder Incontinence Sheet to determine if the resident was incontinent or continent. E21 stated that CNAs were responsible for completion of the 3-day voiding diary and hourly checks were done for those 3 days. E21 stated that once the form was completed, it was determined if the resident was continent or incontinent. When asked who analyzed the data, E21 stated, "I don't know, I know that the MDS office does something with it." When the back of the form was shown to E21, she stated she was unfamiliar with the back of the 3-day voiding dairy. E21 had been employed</p> | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 53 at the facility for over a year.</p> <p>- 9/22/15 at 11:12 AM E2 (DON) stated the expectation was that on admission, a 3-day voiding diary was done to determine bladder patterning. If a resident was continent, a voiding diary was not necessary. It was expected that the Admission Data Collection Tool was filled out and at midnight, on the day of admission, a voiding diary was initiated. Upon completion of the diary, in the clinical daily meetings, the IDT team would implement an individualized care plan. E2 stated the IDT team was comprised of the MDS coordinator, therapy department, DON, ADON, nursing supervisors (including relief supervisors), and CNA's. E2 stated once a care plan was initiated, this was communicated to staff via the 24 hour report, that was read everyday by the nurses and the Kardex was updated for the CNAs. E2 stated Caretracker does not prompt the CNAs when to complete a task, such as toileting, but the CNAs were able to document multiple times during a shift. He also stated that CNAs were not documenting after every care provided, rather they were only charting once per shift. E2 stated that management was working on point of care (electronic system) charting instead of end of shift charting. No additional information was provided to the surveyor before the exit.</p> <p>- The facility failed to complete a 3-day voiding diary upon R12's admission to the facility on 5/14/15.</p> <p>- R12 developed 2 UTIs while in the facility and was hospitalized for urosepsis with the 2nd UTI.</p> <p>- R12 declined from frequently incontinent on the 5/21/15 admission MDS to always incontinent on the 8/12/15 quarterly MDS.</p> <p>- There was a lack of documentation showing that</p> | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 54</p> <p>R12 was tolleted or given incontinence care for 6 shifts.</p> <ul style="list-style-type: none"> - The facility failed to thoroughly complete the Bladder Incontinence Assessment twice, on R12 's admission and readmission from the hospital. - The facillty failed to revlse the care plan when R 12 returned from the hospital. - The facility failed to develop and Implement an individualized tolleting plan based on a voiding dalry. - The facillty failed to re-assess the resident's continence status. <p>R12 progressively declined in urinary contlnence.</p> <p>2. R7 was admitted to the facility on 6/3/15 with diagnoses that included dementia, BPH and a hlstory of CVA.</p> <p>The facility's admission Data Collection Tool, dated 6/3/15, stated R7 was alert and oriented to person and place, his short and long term memory was intact, and he was incontinent of bladder and used pads or briefs.</p> <p>A Bladder Incontinence Assessment, dated 6/3/ 15, was incomplete. It failed to identify contributing factors/diagnoses that could influence R7's continence status, such as dementia and urinary disorders from the prostate. The section "Bladder Status" on page 1 was blank, except for a notation that the buttocks had some redness. Page 2 of the assessment (identifies any abnormal laboratory values which may be potential causes of incontinence and identifies dlagnostic exams performed) was blank . Page 3 of the assessment, which was to be completed after review of Bladder Incontinence Assessment and the 3 Day B&B Flow Sheet to determine whether the resident was</p> | F 315 | | 12-2-15 |

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| F 315 | <p>Continued From page 55</p> <p>recommended for a retraining program, was blank. The Summary portion of the assessment (page 3) stated after review of the Bladder Incontinence Assessment and the 3-Day Bowel and Bladder Flow Sheet; a determination was to be made whether the resident was a candidate for a retraining program. Page 4, the "Bladder Retraining Progress Notes," dated 6/3/15 stated, "Alert and Oriented x 2 (to person and place); Resident stated sometimes he has accidents Resident incontinent of bladder (occasionally) wears pull-ups and adult diapers (per resident). No c/o pain during urination. Soft nondistended abdomen."</p> <p>R7's clinical record revealed that although a 3-Day Bowel & Bladder Flow Sheet (voiding diary) was dated to start at 12 midnight on 6/3/15 (should have been dated 6/4/15), it was not completed. The facility failed to ensure that a voiding diary was completed and they failed to develop an individualized toileting plan based on the voiding diary for R7.</p> <p>An interim care plan, dated 6/3/15, for the problem of incontinence included the following approaches, "If incontinent start B&B pattering (sic); If Incontinence is total check q 2hrs and render good peri care as needed; Tollet before and after meals and at hs and q 4 hrs during the night until my B&B assessment is completed or per my request for toileting; Pads/Briefs/Urinal/ bedpan/bedside Commode as needed."</p> <p>The physician's H&P, dated 6/5/15, did not identify any urinary problems.</p> <p>The electronic Bowel and Bladder Detailed Entry Report, completed by CNAs, from 6/4/15 through</p> | F 315 | | 12-2-15 | |

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| F 315 | <p>Continued From page 56</p> <p>6/10/15, lacked evidence that R7 was being toileted according to the interim Incontinence care plan. Review of the report revealed entries were completed only once per shift and included varied responses, such as, "Toileted per toileting plan; Checking and Changing Pads during rounds; Resident toileted self." There was no evidence that the facility followed the interim plan of care for incontinence.</p> <p>The 6/10/15 admission MDS assessment stated R7's daily decision making skills were severely impaired and he required extensive assist of one staff for transfers and toilet use. This MDS assessment also stated R7 was frequently incontinent during the assessment period (6/4/15 through 6/10/15) and there was no trial of a toileting program.</p> <p>On 6/12/15 a urinary Incontinence care plan was developed. Approaches Included: Incontinence care as needed after each episode of incontinence; monitor for increased episodes of incontinence; and requires the assistance of 1 person for toileting. The approach "Toilet/check/change resident upon rising in AM, before & after meals, at bedtime and every 2 hours during the night" was yellowed out (indicating it was discontinued) and written in was "Check and change q round and PRN." It is unclear when the approach to "check and change q round (usually every 2 hours) and PRN" was implemented, as it was undated.</p> <p>Review of the electronic Resident Bowel and Bladder by Shift Chart, completed by CNAs revealed the following: - 6/4/15 through 6/30/15 consisted of a total of 81 shifts (3 shifts per day) during which R7 was</p> | F 315 | | 12-2-15 |

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| F 315 | <p>Continued From page 57</p> <p>Incontinent on 44 out of the 81 shifts (54.3%).</p> <ul style="list-style-type: none"> - 7/1/15 through 7/31/15 consisted of a total of 93 shifts during which R7 was incontinent on 59 out of the 93 shifts (63.4%). - 8/1/15 through 8/31/15 consisted of a total of 93 shifts during which R7 was incontinent on 69 out of the 93 shifts (74.1%). - 9/1/15 through 9/17/15 (through the 12 AM to 7:30 AM shift) consisted of a total of 49 shifts during which R7 was incontinent on 48 out of the 49 shifts (97.9%). <p>According to the 6/12/15 urinary incontinence care plan, the facility was to monitor for increased episodes of incontinence. Despite progressive decline of R7's urinary incontinence from 6/4/15 through 9/17/15 there was no evidence the facility identified the decline and/or re-assessed the resident.</p> <p>The electronic Bowel and Bladder Detailed Entry Report, completed by CNAs, from 8/27/15 through 9/2/15, lacked evidence that R7 was being toileted according to any scheduled toileting plan. Review of the report revealed entries were completed only once per shift and again had varied responses, such as, "Toileted per toileting plan; Checking and Changing Pads during rounds; Resident toileted self."</p> <p>A quarterly MDS assessment, dated 9/2/15, stated R7's dally decision making skills were severely impaired and he required extensive assist of one staff for transfers and toilet use. The 9/2/15 MDS assessment stated R7 was always incontinent during the assessment period (8/27/15 through 9/2/15) and there was no trial of a toileting program. This was a decline from the 6/10/15 MDS assessment, when R7 was frequently</p> | F 315 | | | 12-2-15 |

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| F 315 | <p>Continued From page 58 Incontinent.</p> <p>On 9/17/15 at 11:40 AM during an interview with R7, he stated that he knows when he needs to use the bathroom to urinate, but at times has some "accidents."</p> <p>On 9/17/15 at approximately 3:00 PM, E11 (CNA) was interviewed. E11 stated that she has worked with R7 for approximately 3 to 4 weeks since he transferred to the 700 wing. E11 stated R7 was able to stand, pivot and transfer with one (1) person assist and was a one (1) person assist for toileting. E11 stated that she toilets R7 before meals and then once in the afternoon. E11 stated the resident was not on a scheduled toileting program (as part of the plan of care), this was just what she does as a routine with her residents. E11 stated that R7 will use the bathroom to urinate, that he may be wet at times, but he will still urinate into the toilet.</p> <p>On 9/21/15 at approximately 10:45 AM, E13 (LPN) was interviewed. E13 stated that the medication nurse assigned to the room is responsible for completing the nursing admission assessment (Data Collection Tool) when a new resident is admitted. E13 stated that the Bladder Incontinence Assessment is completed as part of the admission assessment, and the 11:00 PM to 7:00 AM shift starts a 3-Day Bowel & Bladder Flow Sheet on all residents who have Incontinence. When the diary is completed, the nurse on duty reviews it and determines if the resident is appropriate for a toileting plan. E13 stated that specific times (hours) are not used and CNAs are told to check residents at least every two (2) hours and to assist them to the bathroom or check to see if they are wet.</p> | F 315 | | 12-2-15 | |

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| F 315 | Continued From page 59 On 9/21/15 at 11:10 AM, E8 (CNA) was interviewed. When asked how does a CNA know what care a resident needs, she stated they get report from the nurse and check the yellow sheet (Kardex). She stated if a resident is on a "toileting plan," the nurse lets them know, but there are no specific times told to them by the nurse, nor is it noted in the Caretracker system. E8 stated if she is told a resident is on a toileting plan it means " check and take to the bathroom every two (2) hours and make sure they are not wet." E8 stated that CNAs can document more than once a shift in Caretracker and they are supposed to enter the activity completed each time they leave a resident's room. On 9/22/15 at approximately 11:15 AM, E14 (LPN) was interviewed. E14 stated that the medication nurse assigned to the room completes the nursing admission assessment, which includes the Data Collection Tool and the Bladder Incontinence Assessment. E14 stated the resident and/or family are interviewed regarding the resident's urinary continence status. She stated a 3-Day Bowel & Bladder Flow Sheet is started by the 11 PM to 7 AM shift for all residents with incontinence. E14 stated that when completed, the 3-day diary gets handed in to E2 or E3 (ADON), who then evaluate it and determine if the resident is appropriate for a retraining program. She stated if a toileting program is to be started it is communicated to the nursing supervisor, who then communicates it to the nurse, who then tells the CNAs. E14 stated there is no one resident on her assignment who is currently on a scheduled toileting plan and she has never had anyone on an actual scheduled toileting plan since she's worked at the facility. | F 315 | | 12-2-15 |

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| F 315 | <p>Continued From page 60</p> <p>She stated she encourages the CNAs to take the residents to the bathroom frequently.</p> <p>On 9/22/15 at 11:30 AM, E2 was interviewed. E2 stated that if a resident has Incontinence on admission to the facility, a 3-day diary is to be started at midnight and after completion it is reviewed and a care plan is developed. E2 stated review of the 3-day diary is done at "Clinical Meeting," held daily, which is attended by the DON, ADON, MDS Coordinator, Nurse Supervisor and the therapy department. E2 stated that the nurses are to read the 24 hour report to check if a resident is being placed on a toileting plan and the CNAs are to check the Kardex. E2 stated the Caretracker system does not prompt the CNAs when to complete toileting, but they are able to enter documentation more than once a shift. E2 stated that the facility identified the CNAs were not documenting in Caretracker as they should be, meaning documenting each time after care was provided, and are only documenting once a shift. However, they (management) have not had time to fully act on this discovery. Findings were reviewed with E2 regarding R7's Incontinence. E2 stated he would like the opportunity to review R7's chart on his own. No additional information was provided to the surveyor before the exit.</p> <p>The facility failed to accurately and comprehensively assess R7's urinary continence status upon admission, failed to complete a 3-Day Bowel & Bladder Flow Sheet, and failed to, based on voiding patterns, develop an individualized toileting plan in an attempt to restore as much normal bladder function as possible. Upon admission to the facility, R7 was frequently incontinent of bladder. R7</p> | F 315 | | 12-2-15 | |

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| F 315 | Continued From page 61 progressively declined, yet there was no evidence the facility identified the decline and acted accordingly. There was no evidence of any re-assessment and R7 progressed from frequently incontinent to being always incontinent. Findings were reviewed with E1 (ED), E2 and E3 (ADON) on 9/23/15 during the exit conference at approximately 4:20 PM. | F 315 | F323 1. Resident 10 resides at the facility and is stable. Resident 10 was assessed by Rehab services and the Geri chair is appropriate for the resident. A root cause analysis was completed to identify any additional residents' safety risks and integrated into the resident plan of care at this time | 12-2-15 |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by Cross refer F248 Based on observations, record review and interviews, it was determined that the facility failed to ensure that one (R10) resident out of 34 Stage 2 sampled residents, with severely impaired cognition and a history of unwitnessed falls, received adequate supervision to prevent a fall with injury. R10's fall from a geri chair on 8/5/15 was unwitnessed and without adequate supervision which resulted in the resident sustaining a broken hip that required hospitalization. However, due to R10's high risk for surgery, her advanced age and dementia, surgery was not performed. R10 returned to the | F 323 | the resident is not in need of increased supervision. 2. All residents who use Geri Chair are at risk of being impacted from this practice. Rehab services will assess all residents who use Geri chairs for appropriateness. IDT meeting will review and update care plans any residents identified increase their risk for falls. 3. Facility allegedly failed to appropriately assess the resident's use of a Geri chair and evaluating resident's need for diversionary interventions. Prior to initiating the use of a Geri chair, the rehab department will assess the resident and determine if the use of the Geri chair is appropriate. Any resident identified with psychological issues that increase their risk for falls will be discussed at the IDT meeting to identify appropriate diversionary interventions. Any resident who has had a fall from a Geri chair will | 12-2-15 |

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| F 323 | <p>Continued From page 62</p> <p>facility for palliative care for the broken hip. Additionally, the facility failed to ensure that 4 (501, 502, 605, and 606) out of 31 rooms were free from accident hazards. Findings Include:</p> <p>The facility's Fall Management Program (Revised 10/27/11) stated, "...To provide a systemic review (sic) the resident to determine risk for falls and develop appropriate interventions...</p> <p>3.1 Definitions: A fall is any sudden, unintentional change in position that causes an individual to land at a lower level on an object, the floor or ground. Falls Include: Found on floor, Slides to floor unassisted...3.2...1. Fall Risk Factors...a. Intrinsic Risk Factor (Internal) Included, "History of previous falls. b. ...Inactivity, boredom..."</p> <p>1. Review of R10's clinical record revealed that on 12/1/14 at 3:00 PM, R10 "was found on the floor in her room between her wheelchair and her geri-chair. R10 was placed back in her geri-chair via hooyer lift ". R10 did not sustain an injury.</p> <p>According to R10's quarterly MDS assessment, dated 2/5/15, this resident had a dlagnosis of dementia. R10's quarterly MDS assessment, dated 2/5/15, failed to reflect the 12/1/14 fall without injury under the Fall history section.</p> <p>2/5/15- R10's fall risk assessment using a standardized quarterly "Fall Risk Review Tool" failed to identify the 12/1/14 fall under R10's history of falls. R10 was incorrectly given a score of 0 (no falls within the last 3 months).</p> <p>2/12/15 - R10 was care planned (Initiated 8/23/13) for "Potential for injury related to being a fall risk due to decreased mobility, decreased cognition/ lack of safety awareness, episodes of anxiety/</p> | F 323 | <p><i>F 323</i></p> <p>be re- evaluated by rehab for appropriate use of Geri chair. The nursing and rehab staff will be in serviced by the DON/Designee on the procedure to assess any resident prior to initiating a Geri chair use.</p> <p>4. DON/Designee will audit all residents who have a fall from Geri chair to ensure that rehab has evaluated the resident for continued appropriateness use of Geri chair weekly x 4 weeks until 100% compliance then monthly x2 months until 100% compliance. The findings will be brought to QAPI to determine further monitoring.</p> <p>1. All toilet bolts were tightened and covered, A/C unit covers were installed.</p> <p>2. All residents' resident rooms could be affected by this practice. An environmental round was completed of every room. All toilet bolts were covered and all A/C unit covers are in place.</p> <p>3. The facility failed to identify the need to cover toilet bolts that needed covers and A/C unit covers</p> | <i>12-2-15</i> |

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| F 323 | <p>Continued From page 63</p> <p>behaviors, hx of falls, medication, adl decline". The stated goal was that R10 would have no injury related to falls. The Care plan approaches included: administer medication per order, ensure foot wear has non-skid soles, keep bed in lowest position safest for me, keep call bell in reach encourage to use prn, Therapy evaluation/screen/treat, toilet/incontinence care every round and prn, Transfer with 1 assist, mechanical lift (hoyer lift) x 2 assist, bed and chair alarms, hipsters, and fall mat.</p> <p>3/20/15 - a physician's order stated, DNR/DNH (Do not Resuscitate/Do not Hospitalize) comfort care and RN may pronounce.</p> <p>4/29/15 at 4:15 PM incident report stated, " Responding to Resident's calls for help from... Resident noted sitting on floor in front of her Geri-Chair. Resident was unable to describe or explain incident." There was no Injury documented. The facility's incident report lacked evidence that a chair alarm and hipsters were in place as per R10 's care plan. E2's (DON) written statement, dated 4/30/15, on the facility's investigation report stated that R10 was provided with a dycem on the geri-chair to prevent R10 from sliding.</p> <p>4/30/15- dycem to geri-chair was added to R10's care plan.</p> <p>5/7/15- The annual MDS assessment stated, R10 's cognition remained severely impaired. R10 needed extensive assistance of staff for all ADLs. The MDS assessment only reflected R10's most recent fall of 4/29/15. R10's clinical record lacked evidence of a quarterly Fall Risk Review Tool assessment to determine R10's risk for falls, in conjunction with the annual MDS assessment.</p> | F 323 | <p>F 323</p> <p>were missing. The inspection of toilet bolt covers and A/C unit cover are added to the environmental rounds list. The Administrator in-serviced the Environmental Director on the need of toilet bolt and a/c unit covers.</p> <p>4. Toilet bolt and A/C unit covers will be inspected weekly for placement x2 weeks until 100% then monthly until 100%. Results will be brought to QAPI to determine further monitoring.</p> | 12-2-15 |

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| F 323 | Continued From page 64 5/13/15 at 5:00 PM - Incident Report stated, "Resident noted sitting on floor in her room, in front of her recliner (geri-chair). Stated that she slide (sic) out of chair to the floor. R10 did not sustain injury. This report stated that R10 was "provided with a new dycem - old dycem worn out". There was no evidence that the facility revised the care plan and identified the need for more appropriate interventions such as the need for adequate supervision to prevent the resident from sliding out of the chair and sustaining a fall with injury. 5/14/15 -E5's (OT) note stated, "O.T. completed a f/u screen s/p fall out of her geri-chair. Pt. continues at her PLOF...with all cares...No dycem currently under resident in geri-chair, OT acquired and placed under resident as per care plan. No further skilled OT/PT interventions required at this time". It is unclear why the assistive device dycem was not in place. 8/5/15 - R10 had another unwitnessed fall while in her geri-chair. An incident report dated 8/5/15 at 6:45 PM stated, "Resident found sitting on the floor in front of her chair (geri-chair), no signs and symptoms of injuries noted with initial evaluation. Resident complained of pain afterwards, X-rays obtained". X-Ray result dated 8/5/15 showed "left femoral neck fracture" (a hip fracture proven to be serious injuries in the elderly population that are associated with high mortality and significant morbidity in the geriatric population)- Medscape Drug, Diseases and Procedures reference on Femoral Neck Fracture Imaging updated 10/29/2013), http://emedicine.medscape.com/article/390598-overview . R10 was sent to the hospital | F 323 | | 12-2-15 | |

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| F 323 | <p>Continued From page 65 for evaluation and treatment with the family's consent. R10 was hospitalized from 8/5/15 - 8/10/15.</p> <p>According to the Hospital Discharge Summary, dated 8/10/15, R10's diagnoses included "Left femoral neck fracture" and Advanced Dementia. The hospital physician met with R10's family and explained the high risk of surgery considering her advanced age and dementia. R10's family agreed to provide palliative care for R10.</p> <p>9/16/15 at approximately 10:15 AM - R10 was observed in her room, alone in her geri-chair, in a reclined position with her legs elevated and eyes closed. R10's room was approximately 8 rooms away from the nursing station.</p> <p>9/17/15 at 10:55 AM - R10 was observed in her room alone in her padded geri-chair (halfway reclined with elevated legs) with her eyes closed. R10's call bell was laying on her lap, but was not clipped to her gown. R10 was mumbling with her eyes closed. Her left hand touched the call bell on her lap and the call bell slid onto the floor. The surveyor made E15 (CNA) aware that R10's call bell fell onto the floor.</p> <p>9/21/15 at 3:20 PM- interview with E6 (LPN) related to the 8/5/15 fall, he stated that he could not remember if there was a dycem on the geri-chair. Also, R10 was left in her geri-chair in the hallway opposite the door of her room. The CNAs were busy moving residents from the dining room to other residents' rooms when the unwitnessed incident occurred. E6 stated that he was also busy passing medications at that time in the same hallway, but did not see how she fell.</p> | F 323 | | 12-2-15 | |

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| F 323 | <p>Continued From page 66</p> <p>9/21/15 at 3:30 PM- interview with E7 (CNA), she stated that R10 "always tried to move herself down and out of the geri-chair and everybody (staff) knew that. If you (staff) catch her attempting to move down and get out of the geri-chair, she would quickly get herself back up". She also stated that R10 was "very quick". According to E7, she saw R10 sitting on the floor in front of the geri-chair on 8/5/15 parked outside of another resident's room, across from R10's room. E7 stated on 8/5/15 the dycem was on the geri-chair. She also stated that on 8/5/15 she helped E6 put the resident back in the geri-chair manually and with E6, she also helped R10 back to bed. She gave R10 a bed bath and when turning R10 towards her, R10 started to complain of hip pain.</p> <p>R10's unwitnessed/unsupervised falls (3) dated 12/1/14, 4/29/15 and 5/13/15 occurred while R10 was in the geri-chair in her room without staff supervision. R10's last fall on 8/5/15 was also unwitnessed/unsupervised while in her geri-chair, which resulted in a left hip fracture. R10 returned to the facility after 4 days of hospitalization without surgical intervention and placed on palliative care for pain control for her fractured hip.</p> <p>The facility failed to adequately assess/evaluate R10's falls dated 12/1/14, 4/29/15 and 5/13/15 so appropriate interventions were developed to reduce R10's risk of injury from falls, and prevent falls.</p> <p>Findings were discussed with E2 (DON) and E16 (Regional Nurse Consultant) on 9/22/15 at approximately 3:00 PM.</p> | F 323 | | 12-2-15 | |

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| F 333 | <p>Continued From page 68</p> <p>This REQUIREMENT is not met as evidenced by ;</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that residents were free of significant medication errors for one (R30) out of 34 Stage 2 sampled residents. The facility failed to administer the correct doses of a short acting Insulin, Novolog, six times from 9/3/15 through 9/21/15 . Findings include:</p> <p>The facility policy entitled "Medication Management Guidelines," dated 5/28/02, stated, " Purpose To ensure that residents receive medications and treatments per physician orders. To ensure that medications and treatments are administered according to state/federal regulations and nursing standards of practice."</p> <p>R30 entered the facility on 8/20/15 with a diagnosis of Diabetes and received Insulin.</p> <p>A Diabetes care plan initiated on 9/4/15 listed approaches that included: administer medication per md order... monitor accu checks as orderedmonitor for s/s hyper/hypoglycemia q shift...</p> <p>Review of R30's physician's order for September 2015 stated the sliding scale coverage with Novolog Insulin given by injection daily before meals was based upon BS results of 0-200 = 0 units of Novolog; 201-300 = 2 units of Novolog; 301-400 = 4 units of Novolog; greater than 400 = 6 units of Novolog and call MD.</p> <p>Review of R30's 9/15 MAR revealed the sliding scale Novolog Insulin was not administered as</p> | F 333 | | 12-2-15 |

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| F 333 | <p>Continued From page 69</p> <p>ordered on the following dates: -9/3/15 at 7:30 AM, BS was 249 and R30 was incorrectly covered with 3 rather than 2 units of Insulin as ordered and -9/3/15 at 11:30 AM, BS was 285 and R30 was incorrectly covered with 4 units (double the amount) rather than 2 units of Insulin.</p> <p>NN's were reviewed. There were no new physician orders for 9/3/15.</p> <p>On 9/4/15, R30's physician ordered to discontinue the previous sliding scale and the new sliding scale coverage with Novolog Insulin given by Injection before breakfast and dinner was based upon BS results of < 150 = 1 unit of Novolog; 151-200 = 3 units of Novolog; 201-250 = 5 units of Novolog; 251-300 = 7 units of Novolog; 301-350 = 9 units; 351-400 = 11 units; > 400 = 13 units and page MD.</p> <p>Review of R30's 9/16 MAR revealed the sliding scale Novolog Insulin was not administered as ordered on the following dates: -9/8/15 at 4:30 PM, BS was 140 and R30 was not covered with Novolog as per the sliding scale and should have received 1 unit. The next BS reading on 9/9/15 at 7:30 AM was 184; -9/17/15 at 7:30 AM, BS was 133 and R30 was not covered with Novolog as per the sliding scale and should have received 1 unit. The next BS reading on 9/17/15 at 11:30 AM was 245; -9/21/15 at 7:30 AM, BS was 149 and R30 was not covered with Novolog as per the sliding scale and should have received 1 unit. The next BS reading on 9/21/15 at 11:30 AM was 331; and -9/21/15 at 4:30 PM, BS was 90 and R30 was not covered with Novolog as per the sliding scale and should have received 1 unit. The next BS</p> | F 333 | | 12-2-15 | |

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| F 333 | Continued From page 70 reading on 9/22/15 at 7:30 AM was 195. NN's from 9/8/15 through 9/22/15 revealed: -9/21/15 at 11:00 PM - R30's BS at 4:40 PM was 90 and "no coverage per sliding scale." As noted above, the physician's order required that R12 should have received 1 unit of Novolog. In an Interview, on 9/23/15 at 11:16 AM, E20 (RN,UM) confirmed the findings. In an interview, on 9/23/15 at 11:23 AM, E2 (DON) stated that the BS should be covered according to the physician's orders. Findings were also reviewed with E2 at this time. The facility failed to administer Novolog Insulin six times as ordered for R30 in September 2015, as per physician orders and facility policy, resulting in significant medication errors due to the frequency of the errors and the type of medication administered to R30. | F 333 | F362 1. The facility failed to serve the lunch meal on schedule. All dining staff on duty on this day were immediately addressed and a root cause analysis was performed. It was identified that staffing call offs were cause for the delay. 2. All residents are at risk for this deficient practice. 3. The facility failed to have sufficient personnel to carry out the function of the dietary service. Breakfast and lunch was served late on the date identified. The food service director updated and posted service times for meals. The food service director has in serviced the dietary staff on prompt meal delivery times and coverage in any cases of call offs. | 12-2-15 | |
| F 362 SS=E | 483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observations of lunch service on 9/15/15 and interviews, it was determined that the facility failed to have sufficient staff competent to carry out the functions of dietary service. The facility failed to have enough staff to serve lunch | F 362 | 4. Food service director/designee will audit all meal delivery times to residents daily x1 week until 100% compliance is reached, then 3 x weekly x 2 weeks until 100% compliance has been reached, then weekly x 2 weeks until 100% compliance is reached, the one month later to ensure compliance. The audits will be brought to QAPI for further determination. | 12-2-15 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/23/2015 |
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| NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810 | | |
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| F 362 | <p>Continued From page 71 at appropriate times for residents in the main and assisted dining rooms. Findings include:</p> <p>1. Lunch was scheduled to be served in the main DR at 12:15 PM. Observations were made in this area on 9/15/15 from 12:00 PM to 1:25 PM.</p> <p>The first entree was served at 12:45 PM and the last was served at 1:15 PM.</p> <p>There were 20 residents in the main DR and 3 guests. The only staff that served meals continuously was 1 CNA and 1 dietary aide. There were as many as 6-7 people in the kitchen (in same area as the DR) preparing meals at a time, however, there was a wait of 30-60 minutes for entrees. Some of the staff in the kitchen were in and out helping to serve intermittently.</p> <p>S1 (family who wished to remain anonymous) was interviewed on 9/15/15 at 12:45 PM and stated that it's usual for lunch and dinner service to be slow.</p> <p>S2 (family who wished to remain anonymous) was interviewed on 9/15/15 at 1:15 PM and stated that waiting an hour for the entree was usual and sometimes it takes 1 1/2 hours.</p> <p>Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference on 9/23/15 at approximately 4:35 PM.</p> <p>2. During the lunch meal observation on 9/15/15, lunch was scheduled to begin at 12:15 PM in the assisted dining room. Assorted beverages were observed being offered and served, including refills but, no food was delivered or served until the lunch cart arrived at 1:12 PM (57 minutes late</p> | F 362 | | 12-2-15 | |

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| F 362 | Continued From page 72) It was then served to all residents in the room in about 5 minutes. Findings were discussed with E1 and E2 during the exit meeting on 9/23/15. The facility failed to serve the lunch meal on 9/15/15 within the scheduled time frame. 3. During an interview with S3 (resident who wished to remain anonymous) on 9/15/15 at 12:55 PM, S3 stated that it takes a long time to be served meals and it has been worse since the food service provider changed. 4. During an interview with S4 (resident who wished to remain anonymous) on 9/15/15 at approximately 1:00 PM, S4 stated that it takes a long time to be served lunch and dinner, doesn't know why it takes so long, "but we've got no place to go anyway." 5. During an interview with S5 (resident who wished to remain anonymous) on 9/16/15 at approximately 11:00 AM, S5 stated people have been waiting a long time to be served meals in the dining room. S5 stated they have waited an hour and a half to be served, "particularly bad on weekends." 6. Review of Resident Council Meeting minutes revealed the following: 5/20/15 - "May 11th the breakfast wasn't served until 9:45 AM" (due to be served at 8:15 AM). 6/24/15 - "Wait time for meals is too long; sometimes the residents leave the dining room." 7/15/15 - "Dietary currently working on a system to make sure we are starting meals on time. Also they will be sending down a person to start dining room services (lunch or dinner) with drinks, | F 362 | | 12-2-15 | |

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| F 362 | Continued From page 73 soups, etc. and to be doing so as residents get settled into their seat in table to table fashion." 8/19/15 - "There is too much in between time between soup and main entrees. On 8/17/15, the service was too long. The residents are getting up and leaving because it's taking too long." Despite repeated resident complaints during resident council meetings, the facility failed to ensure there was sufficient support personnel competent to carry out the functions of the dietary service. Findings were reviewed with E1, E2 and E3 (ADON) on 9/23/15 during the exit conference at approximately 4:20 PM. | F 362 | F372 1 & 2. The garbage dumpster door was closed immediately. The facility failed to have the garbage dumpster door closed immediately after use. 3. The food service director/ Designee will in service staff on proper procedure of closing the garbage dumpster door right away after use. 4. The food service director/ Designee will audit garbage dumpster door closure 3x a day x 1 week until 100% compliance then daily x 1 week until 100% compliance then weekly x 2 weeks until 100% compliance then one month later to determine compliance. The audits will be brought to QAPI to determine further monitoring. | 12-2-15 | |
| F 372 SS=F | 483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store and dispose of garbage properly. Findings include: 1. On 9/16/15 at 9:08 AM, the dumpster door was observed to be open and there was stagnant brown colored fluid around the dumpster. Findings were confirmed with E12 (FSD) on 9/16/15 at 9:08 AM. Findings were reviewed with E1 (ED) and E2 (| F 372 | | 12-2-15 | |

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| F 372 | Continued From page 74 | F 372 | F441 | | |
| F 441 SS=F | <p>DON) during the exit conference on 9/23/15 at 4:30 PM.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</p> | F 441 | <p>1. No specific individual was cited.</p> <p>2. All Residents residing in the facility may be impacted by this practice of not maintaining an effective infection control program.</p> <p>3. The clinical nurse consultant will in service the DON/Designee on QAPI Infection control. The DON/Designee will maintain facility's monthly infection control log.</p> <p>4. The RNAC/designee will perform an evaluation/analysis of monthly infection control and report to QAPI for analysis and to determine further monitoring. The RNAC/designee will audit the infection control log weekly x 4 weeks until 100% compliance is reached, then every 2 weeks x 2 weeks until 100% compliance then one month after to ensure compliance.</p> <p>F514 1.a. R 10's MDS was modified to reflect the fall on 12/1/14. 1. b. Unable to correct past documentation omissions in the MAR.</p> | 12-2-15 12-2-15 | |

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| F 441 | <p>Continued From page 75 infection.</p> <p>This REQUIREMENT is not met as evidenced by</p> <p>Based on review of facility documents and staff interview, it was determined that the facility failed to maintain an effective infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to analyze the infection data they collected. Findings include:</p> <p>Infection Control Logs were reviewed from March 2015 - August 2015. There was no evidence of data analysis or investigation during this timeframe.</p> <p>During an interview on 9/23/15 at 10:15 AM, E3 (ADON) stated there was no further documentation available for the facility's Infection Control Program. She stated the data was analyzed and no trends were found in the past 6 months. There was no evidence of her or her predecessor's analysis. E2 (DON), also present during the interview, stated that he would provide QA documentation that showed the facility's analysis of infection control data.</p> <p>Quarterly QAPI reports were provided on 9/23/15 at 11:20 AM for the first two quarters of 2015. Review of these documents revealed a quarterly breakdown of infection control data with totals of each type of infection and whether the infections were acquired prior to admission to the facility or while in the facility. The first quarter of 2015 data was listed by month, while the second quarter</p> | F 441 | <p>F 441</p> <ol style="list-style-type: none"> c. Data collection tool was completed for R 10 on 11/12/15. All residents residing in the facility may be impacted by this deficient practice. Resident's fall risk assessment has been completed. The facility failed to perform Quarterly fall risk assessment. MDS assessment failed to identify one of the resident's falls. The licensed nurses failed to follow the facility's policy regarding documentation during and after medication administration. At the end of the shift, the MAR will be reviewed by another nurse not working that cart on that shift to evaluate whether documentation was completed. The DON/ Designee will in-service licensed nurses on documentation following medication administration. The DON/ designee will audit the MAR daily x 2 weeks until 100% Compliance then 3 x a week for 2 weeks until 100% compliance then once a week x2 weeks until 100% compliance then a month later to ensure 100% compliance. The results of the audit will be brought to QAPI for further determination. The DON/ Designee will in-service licensed nursing staff on completing fall assessment | | 10-2-15 |

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| F 441 | Continued From page 76 was combined. The facility failed to maintain an effective infection control program as they lacked analysis of infection control data. Analysis of data should be ongoing and completed monthly. Findings were reviewed with E1 (ED), E2 and E3 during the exit conference on 9/24/15 at approximately 4:30 PM. | F 441 | <i>F441</i> quarterly. The RNAC/ MDS coordinator will audit all residents' charts due for quarterly assessments to ensure that fall risk assessment is completed every week x 4 weeks until 100% compliant then every 2 weeks x4 weeks until 100% compliant then a month later to ensure compliance. The findings will be brought to QAPI to determine further monitoring. | <i>12-2-15</i> | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/ TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the call bell system was functioning in 3 (508, 513, and 514) out of 31 resident rooms. Findings include: 1. An observation was made on 9/15/15 at 12:11 PM of a call bell in room 514 not functioning. 2. An observation was made on 9/16/15 at 10:06 AM of a call bell in room 508 (bedside of R88) not functioning. 3. An observation was made on 9/16/15 at 10:42 AM of a call bell in room 513 (bedside of R104) not functioning. | F 463 | F 463 1. The facility failed to ensure that all call bells were functioning properly. Call bells for rooms 508, 513, and 514 were immediately repaired. 2. All residents are at risk for non-functioning call bells. At the time of the survey all call bells were tested and found to be compliant with proper call bell functioning. 3. Call bells functionality will be tested weekly on a PM system by the Maintenance Director. 4. A sampling of 5 resident rooms will be audited for call bell functionality by the Maintenance Director/Designee daily for 3 days until 100% compliance is achieved, then once per week x 3 weeks until 100% compliance reached, then one month later to ensure | <i>12-2-15</i> | |

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| F 463 | Continued From page 77 Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference on 9/23/15 at approximately 4:40 PM. | F 463 | <i>F 463</i> compliance. Results will be brought to the QAPI team to determine further monitoring. | <i>12-2-15</i> | |
| F 468 SS=D | 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to equip 1 out of 3 corridors with firmly secured handrails on each side. Findings include: An observation was made on 9/15/15 at 2:50 PM of a loose handrail between rooms 609 and 611. An additional observation was made on 9/21/15 at 2:25 PM on the environmental tour. E17 (Housekeeping Supervisor) confirmed the finding at this time. | F 468 | 1. The facility failed to ensure that all handrails in hallways were properly secured. Loose handrails were found between rooms 609 and 611. Handrails were immediately secured. 2. All handrails are at risk for unsecured attachment. All handrails were reviewed during the survey by the Maintenance Director/designee and found to be in good working order securely fastened to the wall. 3. All handrails were placed on a monthly PM system for inspection for security by the Maintenance Director/designee 4. The Maintenance Director/designee will audit all handrails for security daily for 3 days until 100% compliance is achieved, then once per week x 3 weeks until 100% compliance reached, then one month later to ensure compliance. Results will be brought to the QAPI team to determine further monitoring. | <i>12-2-15</i> | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMplete/ ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient | F 514 | | <i>12-2-15</i> | |

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| F 514 | <p>Continued From page 78</p> <p>Information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that clinical records for one (R10) out of 34 stage 2 sampled residents, were complete and accurately documented in accordance with accepted professional standards and practices. Findings include:</p> <ul style="list-style-type: none"> - 2/5/15 - R10's quarterly MDS assessment failed to identify and document this resident's fall that occurred on 12/1/14 under number of falls. -8/11/15- A physicians order for Hydralazine (for high blood pressure) 3 times a day stated to hold for SBP < 100 and HR < 60. -8/15 MAR-lacked documentation of the SBP and HR when the medication Hydralazine was administered at 12 AM and 8:00 AM on 8/15/15. -8/15/ MAR-8/29/15 8:00 AM Klonopin (treatment for panic attack) was not signed off by the medication nurse as administered. -9/15 MAR-Morphine Sulfate (narcotic pain medication) was not signed off as administered on 9/11/15 and 9/18/15 at 5:00 PM and on 9/22/15 at 8:00 AM. -R10 was missing a quarterly Fall Assessment | F 514 | <p>F514</p> <p>Resident 10 still resides at the facility.</p> <p>All residents residing in the facility maybe impacted by this deficient practice.</p> <p>Resident's fall risk assessment has been completed.</p> <p>The facility failed to perform Quarterly fall risk assessment.</p> <p>MDS assessment failed to identify one of the resident's falls.</p> <p>The licensed nurses failed to follow The facility's policy regarding documentation during and after medication administration.</p> <p>At the end of the shift, the MAR Will be reviewed by another nurse not working that cart on that shift to evaluate whether documentation was completed.</p> <p>The DON/ Designee will In service licensed nurses on documentation following medication administration. The DON/ designee will audit the MAR daily x 2 weeks until 100% Compliance then 3 x a week for 2 weeks until 100% compliance then once a week x2 weeks until 100% compliance then a month later to ensure 100% compliance. The results of the audit will be brought to QAPI for further determination.</p> | 12-2-15 | |

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| F 514 | Continued From page 79 Risk tool for 5/15. R10's last fall risk assessment was done on 2/5/15. On 9/17/15 at 3:00 PM, E2 (DON) was interviewed. He stated that the facility stopped using Fall Risk Assessment Tool form to assess residents' risk for falls (3 years ago as per E20/ RN). Currently, the facility is using the Data Collection Tool form to assess residents risk for falls. However, there was no record of a completed Quarterly Data Collection Tool form for 5/15 for R10. Review of the facility's Data Collection Tool form indicated that re-assessments including residents' risk for falls were done on Admission, Readmission, Annual, with Significant Change and Quarterly -as required by state guidelines. Findings were discussed with E2 and E16 (Regional Nurse Consultant) on 9/22/15 at approximately 3:00 PM. | F 514 | F514 service licensed nursing staff on completing fall assessment quarterly. The RNAC/ MDS coordinator Will audit all residents' charts due for quarterly assessments to ensure that fall risk assessment is completed every week x 4 weeks until 100% compliant then every 2 weeks x4 weeks until 100% compliant then a month later to ensure compliance. The findings will be brought to QAPI for further determination. | 12-2-15 |
| F 520 SS=E | 483.75(o)(1) QAA COMMITTEE-MEMBERS/ MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. | F 520 | F 520 1.a. Resident R7 remains at the facility. R7 Incontinence has been assessed and care plan interventions in place. 1.b. Resident R12 remains at the facility. R12 Incontinence has been assessed and care plan interventions in place. 2.a. All residents residing at the facility who are incontinent may be impacted by this practice deficiency. 2.b. All residents residing at the facility who are incontinent may be impacted by this practice deficiency. | 12-2-15 |

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| F 520 | <p>Continued From page 80</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, interview and review of facility documentation, it was determined that the facility failed to identify issues for 2 (R7 and R12) out of 34 Stage 2 sampled residents, in which quality assessment and assurance activities were necessary to develop and implement appropriate plans of action to correct identified quality deficiencies related to their bladder incontinence. Findings include:</p> <p>Cross refer F315 During an interview with E1 (ED) on 9/23/15 at 3:28 PM, and review of the QAA quarterly meeting sign up sheets, the facility had an ongoing QAA committee that met at least quarterly to identify quality deficiencies to ensure that care practices were consistently applied. E1 confirmed that urinary incontinence issues was not an area identified by the committee.</p> <p>Hence the facility failed to ensure that appropriate treatment and services to restore and/or maintain bladder function for two residents (R7 and R12) were implemented. Specifically, the facility failed to:</p> | F 520 | <p>F520</p> <p>3.a. The facility's QAA committee failed to identify and comprehensively assess the resident's urinary incontinence. The Clinical Nurse Consultant will Educate the DON/ ADON/ MDS Coordinator on reporting increased incontinence to the QAA.</p> <p>3.b. The facility's QAA committee failed to identify and comprehensively assess the resident's urinary incontinence. The Clinical Nurse Consultant will Educate the DON/ ADON/ MDS Coordinator on reporting increased incontinence to the QAA.</p> <p>4.a. The DON/ Designee will evaluate increased incontinence reported to the QAA monthly x 3 months to ensure that proper analysis and recommendations have been put in Place. The findings would be brought to QAPI to determine further monitoring.</p> <p>4.b. The DON/ Designee will evaluate increased incontinence reported to the QAA monthly x 3 months to ensure that proper analysis and recommendations have been put in Place. The findings would be brought to QAPI to determine further monitoring.</p> | | 12-2-15 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/23/2015 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER SHIPLEY MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 520 | Continued From page 81 -comprehensively assess the residents' urinary incontinence; -Failed to complete voiding diaries; -Failed to individualize toileting plans; -Failed to prevent UTIs, resulting in the decline of urinary contlnence. Findings were reviewed on 9/23/15 at approximately 4:50 PM with E1 and E2 (DON). | F 520 | | 12-2-15 | |



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor Health Care & Rehab Center
DATE SURVEY COMPLETED: September 23, 2015

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|--|---|--------------------|
| <p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p> | <p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from September 15, 2015 through September 23, 2015. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 68. The Stage 2 survey sample size was 34.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed September 23, 2015 F225, F246, F248, F253, F272, F278, F280, F309, F314, F315, F323, F333, F362, F372, F441, F463, F468, F514 and F520</p> | | <p>12-2-15</p> |

Provider's Signature *[Signature]* Title Executive Director Date 11-25-15



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 677-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor Health Care & Rehab Center

DATE SURVEY COMPLETED: September 23, 2015

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|--|--|---|--------------------|
| <p>9.0 9.4 9.4.10</p> <p>16 Del. C., Chapter 11, § 1162.</p> | <p>Records and Reports</p> <p>Electronic Record Keeping</p> <p>The facility shall provide independent computer access to electronic records to satisfy the requirements of the survey and certification process.</p> <p>This requirement was not met as evidenced by:</p> <p>During the 9/23/15 survey the process was delayed for one hour. The facility offered 5 computers, 4 were in offices occupied by other staff members and one at the nurses' station. The office doors were closed and occupied by staff members. Additionally one delegated area had a family member in it.</p> <p>The facility failed to provide independent computer access to electronic records; hence it delayed the survey process.</p> <p>On 9/23/15 at approximately 4:40 PM, findings were discussed with E1 (ED) and E2 (DON) at the exit conference.</p> <p>Nursing Staffing</p> <p>(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.</p> <p>Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:</p> <p style="text-align: center;">RN/LRN CNA*</p> | <p>9.4.10</p> <p>Facility failed to provide independent computer for electronic medical records. The facility has dedicated the conference room at the health center and will place a computer which will have access electronic medical records.</p> | <p>12/2/15</p> |

Provider's Signature

[Handwritten Signature]

Title

Executive Director

Date

11-25-15



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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Residents Protection

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STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor Health Care & Rehab Center
DATE SURVEY COMPLETED: September 23, 2015

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---------|--|---|--------------------|
| | <p>Day 1 nurse per 15 residents 1 aide per 8 residents</p> <p>Evening 1:23 1:10 Night 1:40 1:20</p> <p>* or RN, LPN, or NAIT serving as a CNA.</p> <p>(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.</p> <p>The law was not met as evidenced by: Three weeks of facility staffing, covering the period of 20 August 2015 through 9 September 2015 inclusive, were reviewed to verify compliance with Delaware Nursing Home Staffing Laws, commonly known as Eagles' Law. The review consisted of data entered on the DLTCRP Staffing Worksheets by Shipley Manor staff, and signed by the Administrator. The TWO (2) citations hereon result from that work.</p> <p>Shipley Manor was found noncompliant with the required 3.28 daily care hours per resident on the following TWO (2) dates. The care hours attained by Shipley for each date are parenthesized.</p> <p>Saturday 29 August 2015 @ (3.17) Saturday 5 September 2015 @ (2.92)</p> <p>Shipley Manor was also found noncompliant with the weekly aide to resident staff ratios on day shift for the week of 3 through 10 September 2015 attaining a 1:9 ratio (1 aide for every 9 residents.) Required is 1 aide for every 8 residents (a 1:8 ratio).</p> <p>On 9/23/15 at approximately 4:40 PM, findings were discussed with E1 (ED) and E2 (DON) at the exit conference.</p> | <p>On 8/29/15 and 9/5/15 The facility failed to meet daily required care hours. Facility failed to meet Aide ration week of 3 through 10 September 2015. The DON/ designee reviews daily staffing to evaluate compliance with daily care hours. The facility were challenged with staff call offs employees leaving the company. Multiple attempts were made to get coverage from Prn staff. The schedule will be reviewed daily on every shift to evaluate compliance with daily care hours. The facility has hired more nurse assistants and is currently actively interviewing for prn Licensed nurses and nurses aids to be utilized under such circumstances. The DON/ designee will review daily staffing/schedule daily x1 week until 100% compliance, then 3 x a week for 2 weeks until 100% compliance, then weekly x 2 weeks until 100% compliance then one month later to ensure compliance. The Audits will be brought to QAPI to determine further monitoring.</p> | <p>12-2-15</p> |

Provider's Signature _____ Title _____ Date _____